HANFORD EMPLOYEE WELFARE TRUST (HEWT)

SUMMARY PLAN DESCRIPTION

PPO and Out-of-Area Medical Plan

for

Employee and Eligible Dependents

Effective Date: January 1, 2014

Medical Claims Administered by UnitedHealthcare

Group Number: 702633

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Introduction

The Hanford Employee Welfare Trust (HEWT) is pleased to provide you with this Summary Plan Description (SPD) which describes your Benefits, as well as your rights and responsibilities, under the Plan.

You and your eligible Dependents are eligible for this plan if you are an Eligible Person as defined in Section 10: Glossary of Defined Terms, and you are employed by a Sponsoring Employer listed in Attachment II.

Note: It is your responsibility to notify your employer of any change of address.

This document describes Benefits for two plans:

1. The ***HEWT PPO Medical Plan for Employees*** - applies to all enrolled employees (and their eligible Dependents) whose homes are located in an area in which UnitedHealthcare network providers are available.
2. The ***HEWT Out-of-Area Medical Plan for Employees*** - applies ONLY to employees (and their eligible Dependents) whose homes are NOT located in an area in which UnitedHealthcare network providers are available. This plan will apply only in rare circumstances because the UnitedHealthcare PPO network covers a majority of the United States. UnitedHealthcare can confirm whether this plan applies to you.

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How to Use This Document

We encourage you to read your SPD and any attached Riders, Addendums and/or Amendments carefully. Many of the sections relate to other sections of the document. You may not have all of the information you need by reading just one section. We especially encourage you to review Section 1: What's Covered – Benefits, Section 2: What's Not Covered – Exclusions, and Section 9: General Legal Provisions.

Keep this SPD and other documents related to your Medical Plan in a safe place for future reference.

Please be aware that your Physician does not have a copy of this SPD, and he or she is not responsible for knowing or communicating your Benefits.

Information About Defined Terms

Because this SPD is a legal document, we want to give you information that will help you better understand it. Certain capitalized words have special meanings. We have defined these words in Section 10: Glossary of Defined Terms. Refer to this section as you read the document to have a better understanding of the SPD and of your Plan.

The words "we," "us," and "our" in this document refer to the ***Plan Administrator*** which is the Hanford Employee Welfare Trust (HEWT). The words "you" and "your" refer to Employees and eligible Dependents who are Covered Persons as the term is defined in Section 10: Glossary of Defined Terms.

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Your Contribution Towards Plan Costs

The Plan requires Covered Persons to contribute towards the cost of the coverage. Contact the Plan Administrator or your employer for information about the portion of the plan cost for which you may be responsible.

Privacy

The health plan is required by law to protect the privacy of certain health information that it may use or disclosure. Employees will be provided with a Notice of Privacy Practices within 90 days of enrollment in the health plan that describes how the health plan may use or disclose your health information, your rights with respect to your health information, and the health plan's duties with respect to your health information. To get a copy of the notice, or if you have questions regarding the protection of your health information, you may contact the Health Plan Privacy Officer at (509) 376-8926.

Customer Service and Claims Submittal

Please make note of the following information that contains Claims Administrator department names and telephone numbers.

The term ***Claims Administrator*** refers to UnitedHealthcare. Following are important Claims Administrator department names and toll free telephone numbers:

Customer Service Representative: 1-(866) 249-7606
(questions regarding coverage or claims)

Personal Health Support/Notification: 1-(866) 249-7606

Mental Health/Substance Use Disorder Services:
1-(866) 249-7606

Prescription Drug Program (Express Scripts): 1-(800) 796-7518

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UnitedHealthcare Vision: 1-(800)-839-3242

Claims Submittal Address:

UnitedHealthcare - Claims
P.O. Box 30555
Salt Lake City, Utah 84130-0555

Requests for Review of Denied Claims and Notice of Complaints:

Name and Address For Submitting Requests:

UnitedHealthcare - Appeals
P.O. Box 30432
Salt Lake City, Utah 84130-0432

Internet:

We also encourage you to visit the Claims Administrator's website, **www.myuhc.com**, to take advantage of several self-service features including: viewing your claims' status, ordering ID cards and finding Network Physicians in your area.

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Section 1: What's Covered--Benefits

This section provides you with information about:

- Accessing Benefits.
- Copayments/Coinsurance and Eligible Expenses.
- Annual Deductible and Out-of-Pocket Maximum.
- Covered Health Services. We pay Benefits for the Covered Health Services described in this section unless they are listed as not covered in Section 2: What's Not Covered--Exclusions.
- Covered Health Services that require you to notify Personal Health Support or the Mental Health/Substance Use Disorder Administrator before you receive them.

Accessing Benefits

Under the PPO Plan, you can choose to receive either PPO Network Benefits or PPO Non-Network Benefits. To obtain PPO Network Benefits you must see a Network Physician or other Network provider.

Under the Out-of-Area Plan, you can choose to receive Benefits from any Physician or provider. Depending on the geographic area, you may have access to Network providers. These providers have agreed to discount their charges for Covered Health Services. If you

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receive Covered Health Services from a Network provider, your Copayment level will remain the same. However, the portion that you owe may be less than if you received services from a PPO Non-Network provider because the Eligible Expense may be a lesser amount.

For the PPO Plan, you must show your identification card (ID card) every time you request health care services from a Network provider. If you do not show your ID card, Network providers have no way of knowing that you are enrolled under the Plan. As a result, they may bill you for the entire cost of the services you receive.

For the Out-of-Area Plan, you should show your identification card (ID card) every time you request health care services so that the provider will know that you are enrolled under the Plan.

Benefits are available only if all of the following are true:

- Covered Health Services are received while the Plan is in effect.
- Covered Health Services are received prior to the date that any of the individual termination conditions listed in Section 8: When Coverage Ends occurs.
- The person who receives Covered Health Services is a Covered Person and meets all eligibility requirements specified in the Plan.

Copayment/Coinsurance

Copayment/Coinsurance is the amount you pay each time you receive certain Covered Health Services. For a complete definition of Copayment and Coinsurance, see Section 10: Glossary of Defined Terms. Copayment and Coinsurance amounts are listed on the following pages next to the description for each Covered Health Service. Your cost will be either Copayments which are set amounts or Coinsurance which is based on a percentage of Eligible Expenses.

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Eligible Expenses

Eligible Expenses for Covered Health Services, incurred while the Plan is in effect, and are the amount that we will pay for Benefits as determined by us or by our designee. In almost all cases our designee is the Claims Administrator. For a complete definition of Eligible Expenses that describes how payment is determined, see Section 10: Glossary of Defined Terms.

We have delegated to the Claims Administrator the discretion and authority to initially determine on our behalf whether a treatment or supply is a Covered Health Service and how the Eligible Expense will be determined and otherwise covered under the Plan.

For Network Benefits, you are responsible for the Copayment and/or Coinsurance and amounts in excess of any plan maximum, but you are not responsible for any difference between the Eligible Expenses and the amount the provider bills, unless you agreed to reimburse the provider for such services. For PPO Non-Network Benefits, except for fees that are negotiated by a non-Network provider and either the Claims Administrator or one of its vendors, affiliates or subcontractors, you are responsible for paying, directly to the PPO Non-Network provider, the Copayment and/or Coinsurance, any difference between the amount the provider bills you and the amount we will pay for Eligible Expenses, and any amounts in excess of any plan maximum.

Notification Requirements

Prior notification is required before you receive certain Covered Health Services. You are responsible for notifying Personal Health Support before you receive these Covered Health Services.

For Mental Health/Substance Use Disorder (MH/SUD) Services you are responsible for notifying the MH/SUD Administrator.

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Services for which you must provide prior notification appear in this section under the *Must You Notify Personal Health Support?* column in the table labeled *Benefit Information*.

To notify Personal Health Support or the MH/SUD Administrator, call the toll free telephone number shown on your ID card, **1-866-249-7606**, for Claims Administration.

We urge you to confirm with Personal Health Support that the services you plan to receive are Covered Health Services, even if not indicated in the *Must You Notify Personal Health Support?* column. That's because in some instances, certain procedures may not meet the definition of a Covered Health Service and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Health Services. By calling the toll free telephone number shown on your ID card, **1-866-249-7606**, before you receive treatment, you can check to see if the service is subject to limitations or exclusions such as:

- The Cosmetic Procedures exclusion. Examples of procedures that may or may not be considered Cosmetic include: breast reduction and reconstruction (except for after cancer surgery when it is always considered a Covered Health Service); vein stripping, ligation and sclerotherapy, and upper lid blepharoplasty.
- The Experimental, Investigational or Unproven Services exclusion.
- Any other limitation or exclusion of the Plan.

Special Note Regarding Medicare

If you are enrolled for Medicare and on disability on a primary basis (Medicare pays before we pay Benefits under the Plan), the notification requirements described in this SPD do not apply to you.

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Since Medicare is the primary payer, we will pay as secondary payer as described in Section 7: Coordination of Benefits. You are not required to notify Personal Health Support before receiving Covered Health Services when Medicare is the primary payer.

Special Note Regarding Mental Health and Substance Use Disorder Services

You must provide pre-service notification as described below.

When Benefits are provided for any of the services listed below, the following services require notification:

- Mental Health Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility); intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.

- Substance Use Disorder Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility); intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.

For a scheduled admission, you must notify the MH/SUD Administrator prior to the admission, or as soon as reasonably possible for non-scheduled admissions (including Emergency admissions). If you fail to notify the MH/SUD Administrator as required, Benefits may be reduced.

In addition, you must notify the MH/SUD Administrator before the following services are received. If you fail to notify the MH/SUD Administrator as required, Benefits may be reduced. Services requiring prior notification are:

- Intensive outpatient program treatment.

- Outpatient electro-convulsive treatment.

- Psychological testing.

- Extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.

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Payment Information

Payment Term	Description	Amounts
Annual Deductible	The amount you pay for Covered Health Services before you are eligible to receive Benefits. For a complete definition of Annual Deductible, see Section 10: Glossary of Defined Terms. The actual amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. For a complete definition of Eligible Expenses, see Section 10: Glossary of Defined Terms. ***PPO Network/Out-of-Area Plan*** Covered Expenses charged by both Network and non-Network providers apply towards both the Network Individual and Family Deductible Maximums and the non-Network Individual and Family Deductible Maximums.	***PPO Network/Out-of-Area Plan*** $325 per Covered Person per calendar year not to exceed $650 for all Covered Persons in a family. ***PPO Non-Network*** $425 per Covered Person per calendar year not to exceed $850 for all Covered Persons in a family.

Payment Term	Description	Amounts
Out-of-Pocket Maximum	The maximum you pay, out of your pocket, in a calendar year for Coinsurance. For a complete definition of Out-of-Pocket Maximum, see Section 10: Glossary of Defined Terms. **PPO Plan:** Covered Expenses charged by both Network and Non-Network providers apply towards both the Network Individual and Family Out-of-Pocket Maximums and the non-Network Individual and Family Out-of-Pocket Maximums.	***PPO Network/Out-of-Area Plan*** $1,350 per Covered Person per calendar year not to exceed $2,700 for all Covered Persons in a family. The Out-of-Pocket Maximum includes the Annual Deductible. ***PPO Non-Network*** $3,500 per Covered Person per calendar year not to exceed $7,000 for all Covered Persons in a family The Out-of-Pocket Maximum includes the Annual Deductible.

Payment Term	Description	Amounts
Maximum Plan Benefit	There is no dollar limit to the amount the Plan will pay for essential Benefits during the entire period you are enrolled in this Plan. Generally the following are considered to be essential benefits under the Patient Protection and Affordable Care Act: Ambulatory patient services; emergency services, hospitalization; maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.	No Maximum Plan Benefit.

Benefit Information

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Or Coinsurance Amount % Coinsurance is based on a percent of Eligible Expenses	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
1. Acupuncture Services Acupuncture services for pain therapy when the following is true: • The service is performed by a provider in the provider's office. Where such Benefits are available, acupuncture is a Covered Health Service for the treatment of: • Nausea of Chemotherapy, or • Post-operative nausea, or • Nausea of early Pregnancy. Any combination of **PPO Network and PPO Non-Network Benefits** are limited to 20 visits per calendar year. Benefits are limited to 20 visits per calendar year under the **Out-of-Area Plan**	***PPO Network*** No	20%	Yes	Yes
	PPO Non-Network No	40%	Yes	Yes
	Out-of-Area No	20%	Yes	Yes

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Or Coinsurance Amount % Coinsurance is based on a percent of Eligible Expenses	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
2. Ambulance Services - Emergency only Emergency ambulance transportation by a licensed ambulance service to the nearest Hospital where Emergency Health Services can be performed.	***PPO Network*** No	*Ground Transportation* 20%	Yes	Yes
		Air Transportation 20%	Yes	Yes
	PPO Non-Network No	Same as PPO Network		
	Out-of-Area No	Same as PPO Network		
3. Ambulance Services - Non-Emergency Transportation by professional ambulance, other than air ambulance, to and from a medical facility. Transportation by regularly-scheduled airline, railroad or air ambulance, to the nearest medical facility qualified to give the required treatment.	***PPO Network*** Yes	20%	Yes	Yes
	PPO Non-Network Yes	40%	Yes	Yes
	Out-of-Area Yes	20%	Yes	Yes

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Or Coinsurance Amount % Coinsurance is based on a percent of Eligible Expenses	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Notify Personal Health Support Please remember that you should notify Personal Health Support as soon as possible. When you provide notification, Personal Health Support can verify that the service is a Covered Health Service. If you don't notify Personal Health Support, Benefits will be reduced to 40% of Eligible Expenses.				
4. Clinical Trials Benefits are available for routine patient care costs incurred during participation in a qualifying Clinical Trial for the treatment of: • cancer or other life-threatening disease or condition. For purposes of this benefit, a life-threatening disease or condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted; • cardiovascular disease (cardiac/stroke) which is not life threatening, for which, as the Claims Administrator determines, a Clinical Trial meets the qualifying Clinical Trial criteria stated below; • surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, for which, as the Claims Administrator determines, a Clinical Trial meets the qualifying Clinical Trial criteria stated below; and • other diseases or disorders which are not life threatening for which, as the Claims Administrator determines, a Clinical Trial meets the qualifying Clinical Trial criteria stated below. Benefits include the reasonable and necessary items and services used to prevent, diagnose and treat complications arising from participation in a	***PPO Network*** Yes ***PPO Non-Network*** Yes ***Out-of-Area*** Yes	Same as Professional Fees, Hospital-Inpatient Stay and Outpatient Diagnostic and Therapeutic Services. Same as Professional Fees, Hospital-Inpatient Stay and Outpatient Diagnostic and Therapeutic Services. Same as Professional Fees, Hospital-Inpatient Stay and Outpatient Diagnostic and Therapeutic Services.		

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Or Coinsurance Amount % Coinsurance is based on a percent of Eligible Expenses	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
qualifying Clinical Trial. Benefits are available only when the Covered Person is eligible for participation in the qualifying Clinical Trial according to the Clinical Trial protocol and such participation would be appropriate based on 1) medical and scientific information provided by the Covered Person or 2) the conclusion of a referring health care professional that is participating in the Clinical Trial. Routine patient care costs for qualifying Clinical Trials include: • Covered Health Services for which Benefits are typically provided absent a Clinical Trial; • Covered Health Services required solely for the provision of the investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and • Covered Health Services needed for reasonable and necessary care arising from the provision of an investigational item or service. • Routine costs for Clinical Trials do not include: • the Experimental or Investigational Service or item. The only exceptions to this are: - certain Category B devices; - certain promising interventions for patients with terminal illnesses; and - other items and services that meet specified criteria in accordance with the Claims Administrator's medical and drug policies; • items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management				

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Or Coinsurance Amount % Coinsurance is based on a percent of Eligible Expenses	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?

of the patient;

- a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; and
- items and services provided by the research sponsors free of charge for any person enrolled in the trial.

With respect to cancer or other life-threatening diseases or conditions, a qualifying Clinical Trial is a Phase I, Phase II, Phase III, or Phase IV Clinical Trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and which meets any of the following criteria in the bulleted list below.

With respect to cardiovascular disease or musculoskeletal disorders of the spine and hip and knees and other diseases or disorders which are not life-threatening, a qualifying Clinical Trial is a Phase I, Phase II, or Phase III Clinical Trial that is conducted in relation to the detection or treatment of such non-life-threatening disease or disorder and which meets any of the following criteria in the bulleted list below.

- federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - National Institutes of Health (NIH). (Includes National Cancer Institute (NCI));
  - Centers for Disease Control and Prevention (CDC);
  - Agency for Healthcare Research and Quality (AHRQ);
  - Centers for Medicare and Medicaid Services (CMS);
  - a cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Department of Veterans Affairs (VA);
  - a qualified non-governmental research entity identified in the

guidelines issued by the National Institutes of Health for center support grants; or

- the Department of Veterans Affairs, the Department of Defense or the Department of Energy as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the Secretary of Health and Human Services to meet both of the following criteria:
  - ♦ comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and
  - ♦ ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

- the study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration;
- the study or investigation is a drug trial that is exempt from having such an investigational new drug application;
- the Clinical Trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. The Claims Administrator may, at any time, request documentation about the trial; or
- the subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Plan.

Notify Personal Health Support

Please remember that you should notify Personal Health Support as soon as the possibility of participation in a Clinical Trial arises. If you don't notify Personal Health Support, Benefits will be reduced to 40% of

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Or Coinsurance Amount % Coinsurance is based on a percent of Eligible Expenses	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Eligible Expenses.				
5. Congenital Heart Disease Services Covered Health Services for Congenital Heart Disease (CHD) services when ordered by a Physician. CHD services may be received at a Congenital Heart Disease Resource Services program. Benefits are available for the CHD services when the services meet the definition of a Covered Health Service, and are not an Experimental, Investigational or an Unproven Service. Personal Health Support notification is required for all CHD services, including outpatient diagnostic testing, in utero services and evaluation. • Congenital heart disease surgical interventions. • Interventional cardiac catheterizations. • Fetal echocardiograms. • Approved fetal interventions. The services described under **Transportation and Lodging** below are Covered Health Services **ONLY** in connection with CHD services received at a Congenital Heart Disease Resource Services program. CHD services other than those listed above are excluded from coverage, unless determined by Personal Health Support to be a proven procedure for the involved diagnoses. Contact Personal Health Support at the telephone number on your ID card for information about CHD services. **Transportation and Lodging** Personal Health Support will assist the patient and family with travel and lodging arrangements. Expenses for travel, and lodging for the recipient of	***PPO Network*** Yes ***PPO Non-Network*** Yes ***Out-of-Area*** Yes	20% 40% 20%	Yes Yes Yes	Yes Yes Yes

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Or Coinsurance Amount % Coinsurance is based on a percent of Eligible Expenses	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?

CHD services and a companion are available under this Plan as follows:

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of CHD services for the purposes of an evaluation, the procedure or necessary post-discharge follow-up.
- Eligible Expenses for lodging for the patient (while not confined) and one companion. Benefits are paid at a per diem rate of up to $50 for one person or up to $100 for two people.
- Travel and lodging expenses are only available if the CHD recipient resides more than 50 miles from the Congenital Heart Disease Resource Services program.
- If the patient is an Enrolled Dependent minor child, the transportation expenses of two companions will be covered and lodging expenses will be reimbursed up to the $100 per diem rate.

There is a combined overall lifetime maximum Benefit of $10,000 per Covered Person for all transportation, and lodging expenses incurred by the CHD recipient and companion(s) and reimbursed under this Plan in connection with all CHD procedures.

Notify Personal Health Support

You must notify Personal Health Support as soon as CHD is suspected or diagnosed (in utero detection, at birth, or as determined and before the time an evaluation for CHD is performed). If you don't notify Personal Health Support, Benefits will be reduced to 40% of Eligible Expenses.

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Or Coinsurance Amount % Coinsurance is based on a percent of Eligible Expenses	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
6. Dental Services - Accident only Dental services when all of the following are true: • Treatment is necessary because of accidental damage. • Dental services are received from a Doctor of Dental Surgery, "D.D.S." or Doctor of Medical Dentistry, "D.M.D." • The dental damage is severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident. The Plan also covers dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition limited to: • Dental services related to medical transplant procedures; • Initiation of immunosuppressives (medication used to reduce inflammation and suppress the immune system); and • Direct treatment of acute traumatic Injury, cancer or cleft palate. Benefits are available only for treatment of a sound, natural tooth. The Physician or dentist must certify that the injured tooth was: • A virgin or unrestored tooth, or • A tooth that has no decay, no filling on more than two surfaces, no gum disease associated with bone loss, no root canal therapy, is not a dental implant and functions normally in chewing and speech.	***PPO Network*** Yes	20%	Yes	Yes
	PPO Non-Network Yes	40%	Yes	Yes
	Out-of-Area Yes	20%	Yes	Yes

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Or Coinsurance Amount % Coinsurance is based on a percent of Eligible Expenses	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Dental services for final treatment to repair the damage must be both of the following: • Started within three months of the accident. • Completed within 12 months of the accident. Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered an "accident". Benefits are not available for repairs to teeth that are injured as a result of such activities. **Notify Personal Health Support** Please remember that you should notify Personal Health Support as soon as possible, but at least five business days before follow-up (post-Emergency) treatment begins. (You do not have to provide notification before the initial Emergency treatment.) When you provide notification, Personal Health Support can verify that the service is a Covered Health Service. If you don't notify Personal Health Support, Benefits will be reduced to 40% of Eligible Expenses.				
7. Durable Medical Equipment Durable Medical Equipment that meets each of the following criteria: • Ordered or provided by a Physician for outpatient use. • Used for medical purposes. • Not consumable or disposable, except if part of the covered equipment. • Not of use to a person in the absence of a disease or disability. If more than one piece of Durable Medical Equipment can meet your	***PPO Network*** Yes, for items more than $1,000.	20%	Yes	Yes
	PPO Non-Network Yes, for items more than $1,000.	40%	Yes	Yes

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Or Coinsurance Amount % Coinsurance is based on a percent of Eligible Expenses	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
functional needs, Benefits are available only for the most cost-effective piece of equipment. Examples of Durable Medical Equipment include: • Equipment to assist mobility, such as a standard wheelchair. • A standard Hospital-type bed. • Oxygen concentrator units and the rental of equipment to administer oxygen. • Delivery pumps for tube feedings. • Mechanical equipment necessary for the treatment of chronic or acute respiratory failure or conditions. • External cochlear devices and systems. Surgery to place a cochlear implant is also covered by the Plan. Cochlear implantation can either be an inpatient or outpatient procedure. • Braces that stabilize an Injured body part are considered Durable Medical Equipment and are a Covered Health Service, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices and are excluded from coverage. Dental braces are also excluded from coverage. • Ostomy supplies. Benefits for ostomy supplies are limited to: —Pouches, face plates and belts. —Irrigation sleeves, bags and ostomy irrigation catheters. —Skin barriers. • Mechanical equipment necessary for the treatment of chronic or acute respiratory failure or conditions.	***Out-of-Area*** Yes, for items more than $1,000.	20%	Yes	Yes

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Or Coinsurance Amount % Coinsurance is based on a percent of Eligible Expenses	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?

- External cochlear devices and systems. Surgery to place a cochlear implant is also covered by the Plan. Cochlear implantation can either be an inpatient or outpatient procedure.

We provide Benefits for a single unit of Durable Medical Equipment (example one insulin pump) and provide repair for that unit.

Benefits are provided for the replacement of a type of Durable Medical Equipment once every three calendar years.

At the Claim Administrator's discretion, replacements are covered for damage beyond repair with normal wear and tear, when repair costs exceed new purchase price, or when a change in the Covered Person's medical condition occurs sooner than the three year timeframe. Repairs, including the replacement of essential accessories, such as hoses, tube, mouth pieces, etc., for necessary DME are only covered when required to make the item/device serviceable and the estimated repair expense does not exceed the cost of purchasing or renting another item/device. Requests for repairs may be made at any time and are not subject to the three year timeline for replacement.

Notify Personal Health Support

Please remember that for PPO Non-Network Benefits you must notify Personal Health Support before obtaining any single item of Durable Medical Equipment that costs more than $1,000 (either purchase price or cumulative rental of a single item). Personal Health Support will decide if the equipment should be purchased or rented. To receive PPO Network Benefits, you must purchase or rent the Durable Medical Equipment from the vendor Personal Health Support identifies.

If you don't notify Personal Health Support, Benefits for Durable Medical

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Or Coinsurance Amount % Coinsurance is based on a percent of Eligible Expenses	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Equipment will be reduced to 40% of Eligible Expenses.				
8. Emergency Health Services Services that are required to stabilize or initiate treatment in an Emergency. Emergency Health Services must be received on an outpatient basis at a Hospital or Alternate Facility. You will find more information about Benefits for Emergency Health Services in Section 3: Obtaining Benefits. **Notify Personal Health Support** To ensure prompt and accurate payment of your claim as a PPO Network Benefit, notify Personal Health Support within two business days or as soon as possible after you receive outpatient Emergency Health Services at a PPO Non-Network Hospital or Alternate Facility. Please remember that if you are admitted to a Hospital as a result of an Emergency, you must notify Personal Health Support within two business days after admission, or as soon as reasonably possible. If you don't notify Personal Health Support, Benefits for the Hospital Inpatient Stay will be reduced to 40% of Eligible Expenses. Benefits will not be reduced for the outpatient Emergency Health Services.	***PPO Network*** Yes, but only for an Inpatient Stay. ***PPO Non-Network*** Yes, but only for an Inpatient Stay. ***Out-of-Area*** Yes, but only for an Inpatient Stay.	$125 per visit plus 20% $125 per visit plus 20% $125 per visit plus 20%	Yes Yes Yes Yes Yes Yes	Yes Yes Yes Yes Yes Yes

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Or Coinsurance Amount % Coinsurance is based on a percent of Eligible Expenses	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
9. Hearing Care Benefits include one annual routine hearing screening to detect hearing impairment. Any combination of **PPO Network and PPO Non-Network**	***PPO Network*** No	20%	Yes	Yes
	Non PPO Network No	40%	Yes	Yes
	Out-of-Area Yes	20%	Yes	Yes
10. Hearing Aids The Plan pays Benefits for hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver. Benefits are available for a hearing aid that is purchased as a result of a written recommendation by a Physician. Benefits are provided for the hearing aid and for charges for associated fitting and testing. Benefits do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Service for which Benefits are available under the applicable medical/surgical Covered Health Services categories in this section only for Covered Persons who have either of the following: • Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.	***PPO Network*** No	20%	Yes	Yes
	Non PPO Network No	40%	Yes	Yes
	Out-of-Area No	20%	Yes	Yes

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Or Coinsurance Amount % Coinsurance is based on a percent of Eligible Expenses	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
• Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid. Benefits are limited to a single purchase (including repair/replacement) per hearing impaired ear every three calendar years. **PPO Plan**: Any combination of Network Benefits and Non-Network Benefits are limited to $300 in a 36 month period. **Out-of-Area Plan**: Benefits are limited to $300 in a 36 month period.				
11. Home Health Care Services received from a Home Health Agency that are both of the following: • Ordered by a Physician. • Provided by or supervised by a registered nurse in your home. Benefits are available only when the Home Health Agency services are provided on a part-time, intermittent schedule and when skilled home health care is required. Skilled home health care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true: • It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient. • It is ordered by a Physician. • It is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or	***PPO Network*** Yes ***PPO Non-Network*** Yes ***Out-of-Area*** Yes	20% 40% 20%	Yes Yes Yes	Yes Yes Yes

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Or Coinsurance Amount % Coinsurance is based on a percent of Eligible Expenses	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?

transferring from a bed to a chair.

- It requires clinical training in order to be delivered safely and effectively.
- It is not Custodial Care.

Personal Health Support will decide if skilled home health care is required by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Any combination of PPO Network and PPO Non-Network Benefits are limited to 40 visits per calendar year.

Out-of-Area Benefits are limited to 40 visits per calendar year. One visit equals four hours of skilled care services.

Notify Personal Health Support

Please remember that you should notify Personal Health Support five business days before receiving services. If you don't notify Personal Health Support, Benefits will be reduced to 40% of Eligible Expenses.

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Or Coinsurance Amount % Coinsurance is based on a percent of Eligible Expenses	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
12. Hospice Care Hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social and spiritual care for the terminally ill person, and short-term grief counseling for immediate family members. Grief counseling must be given within six months after the patient's death and is limited to 15 visits for each family. Benefits are available when hospice care is received from a licensed hospice agency. Respite care is not covered. **Notify Personal Health Support** Please remember that you must notify Personal Health Support five business days before receiving services. If you don't notify Personal Health Support, Benefits will be reduced to 40% of Eligible Expenses.	***PPO Network*** Yes	20%	Yes	Yes
	PPO Non-Network Yes	40%	Yes	Yes
	Out-of Area Yes	20%	Yes	Yes
13. Hospital - Inpatient Stay Inpatient Stay in a Hospital. Benefits are available for: • Services and supplies received during the Inpatient Stay. • Room and board in a Semi-private Room (a room with two or more beds).	***PPO Network*** Yes	20%	Yes	Yes
	PPO Non-Network Yes	40%	Yes	Yes
	Out-of-Area Yes	20%	Yes	Yes

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Or Coinsurance Amount % Coinsurance is based on a percent of Eligible Expenses	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Notify Personal Health Support Please remember that you must notify Personal Health Support as follows: • For elective admissions: five business days before admission. • For Emergency admissions (also known as non-elective admissions): within two business days after admission, or as soon as is reasonably possible. If you don't notify Personal Health Support, Benefits will be reduced to 40% of Eligible Expenses.				
14. Infertility Services Covered Health Services and associated expenses for the diagnosis and treatment of an underlying medical condition which causes infertility when provided by or under the direction of a Physician. Infertility services such as assisted reproductive technology, artificial insemination, in vitro fertilization, GIFT and ZIFT, impregnation or fertilization charges are not covered.	***PPO Network*** No	20%	Yes	Yes
	PPO Non-Network No	40%	Yes	Yes
	Out-of-Area No	20%	Yes	Yes

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Or Coinsurance Amount % Coinsurance is based on a percent of Eligible Expenses	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
15. Injections received in a Physician's Office Benefits are available for injections received in a Physician's office when no other health service is received, for example allergy immunotherapy.	***PPO Network*** No	20% per injection	Yes	Yes
	PPO Non-Network No	40% per injection	Yes	Yes
	Out-of-Area No	20% per injection	Yes	Yes
16. Maternity Services Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications. **There is a special prenatal program to help during Pregnancy.** It is completely voluntary and there is no extra cost for participating in the program. To sign up, you should notify Personal Health Support during the first trimester, but no later than one month prior to the anticipated childbirth.	***PPO Network*** Yes if Inpatient Stay exceeds time frames.	Benefits will be the same as those stated under each Covered Health Service category in this section.		
	PPO Non-Network Yes if Inpatient Stay exceeds time frames.	Benefits will be the same as those stated under each Covered Health Service category in this section.		
	Out-of-Area Yes if Inpatient Stay exceeds time frames.	Benefits will be the same as those stated under each Covered Health Service category in this section.		

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Or Coinsurance Amount % Coinsurance is based on a percent of Eligible Expenses	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?

We will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a vaginal delivery.
- 96 hours for the mother and newborn child following a cesarean section delivery.

These are federally mandated requirements under the Newborns' and Mothers' Health Protection Act of 1996 which apply to this Plan. The Hospital or other provider is not required to get authorization for the time periods stated above. Authorizations are required for longer lengths of stay. If the mother agrees, the attending Physician may discharge the mother earlier than these minimum timeframes.

Notify Personal Health Support

Please remember that you must notify Personal Health Support as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than the time frames described. If you don't notify Personal Health Support that the Inpatient Stay will be extended, your Benefits for the extended stay will be reduced to 40% of Eligible Expenses.

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Or Coinsurance Amount % Coinsurance is based on a percent of Eligible Expenses	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
17. Mental Health Services Mental Health Services include those received on an inpatient basis in a Hospital or Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility. Benefits include the following services provided on either an outpatient or inpatient basis: • Diagnostic evaluations and assessment. • Treatment planning. • Referral services. • Medication management. • Individual, family, therapeutic group and provider based case management services. • Crisis intervention. Benefits include the following services provided on an inpatient basis: • Partial hospitalization/day treatment. • Services at a Residential Treatment Facility. Benefits include Intensive outpatient treatment services provided on an outpatient basis. The MH/SUD Administrator determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis. You are encouraged to contact the MH/SUD Administrator for referrals to providers and coordination of care.	***PPO Network*** You must call the Mental Health / Substance Use Disorder Administrator to receive the Benefits.	**Hospital – Inpatient Stay** 20% per Inpatient Stay.	Yes	Yes
		Physician's Office Services 20% per visit.	Yes	Yes
	PPO Non-Network You must call the Mental Health / Substance Use Disorder Administrator to receive the Benefits.	**Hospital – Inpatient Stay** 40% per Inpatient Stay.	Yes	Yes
		Physician's Office Services 40% per visit.	Yes	Yes
	Out-of-Area You must call the Mental Health/ Substance Use Disorder Administrator to receive the Benefits.	**Hospital – Inpatient Stay** 20% per Inpatient Stay.	Yes	Yes
		Physician's Office Services 20% per visit.	Yes	Yes

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Or Coinsurance Amount % Coinsurance is based on a percent of Eligible Expenses	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Special Mental Health Programs and Services Special programs and services that are contracted under the MH/SUD Administrator may become available to you as part of your Mental Health Services benefits. The Mental Health Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of benefit use. Special programs or services provide access to services that are beneficial for the treatment of your Mental Illness which may not otherwise be covered under this Plan. You must be referred to such programs through the MH/SUD Administrator, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such program or service is at the discretion of the Covered Person and is not mandatory. **Notification Required** Please remember that you must notify the MH/SUD Administrator to receive these Benefits. The MH/SUD Administrator phone number appears on your ID card. Without notification, Benefits will be reduced to 40% of Eligible Expenses.				
18. Nutritional Counseling Covered Health Services provided by a registered dietician in an individual session for Covered Persons with medical conditions that require a special diet. Some examples of such medical conditions include: • Diabetes mellitus. • Coronary artery disease. • Congestive heart failure.	***PPO Network*** No	20%	Yes	Yes
	PPO Non-Network No	40%	Yes	Yes

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Or Coinsurance Amount % Coinsurance is based on a percent of Eligible Expenses	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
	Out-of-Area			
• Severe obstructive airway disease. • Gout. • Renal failure. • Phenylketonuria. • Hyperlipidemias. Benefits are limited to three individual sessions during a Covered Person's lifetime for each medical condition. This limit applies to non-preventive nutritional counseling services only. When nutritional counseling services are billed as a preventive care service, these services will be paid as described under Preventive Care in this section.	No	20%	Yes	Yes

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Or Coinsurance Amount % Coinsurance is based on a percent of Eligible Expenses	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
19. Obesity Surgery Surgical treatment of morbid obesity provided by or under the direction of a Physician. All of the following criteria must be met: • Covered Person must have a minimum Body Mass Index (BMI) of 40 or a minimum BMI of 35 with complicating co-morbidities (such as sleep apnea or diabetes) directly related to, or exacerbated by obesity. • Covered Person must have documentation of a diagnosis of morbid obesity for a minimum of five (5) years from a Physician. • Covered Person must be over the age of 21. **Notify Personal Health Support** Please remember that you must notify Personal Health Support. If you don't notify Personal Health Support, Benefits will be reduced to 40% of Eligible Expenses.	***PPO Network*** Yes ***PPO Non-Network*** Yes ***Out-of-Area*** Yes	20% 40% 20%	Yes Yes Yes	Yes Yes Yes
20. Outpatient Surgery, Diagnostic and Therapeutic Services Covered Health Services received on an outpatient basis at a Hospital or Alternate Facility including: • Surgery and related services. • Lab and radiology/X-ray. • Mammography testing. • Other diagnostic tests and therapeutic treatments (including cancer chemotherapy or intravenous infusion therapy).	***PPO Network*** No ***PPO Non-Network*** No ***Out-of-Area*** No	20% 40% 20%	Yes Yes Yes	Yes Yes Yes

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Or Coinsurance Amount % Coinsurance is based on a percent of Eligible Expenses	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Benefits under this section include only the facility charge and the charge for required services, supplies and equipment. Benefits for the professional fees related to outpatient surgery, diagnostic and therapeutic services are described under *Professional Fees for Surgical and Medical Services* below.				
21. Physician's Office Services - Sickness and Injury Benefits are paid by the Plan for Covered Health Services received in a Physician's office for the evaluation and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the Physician's office is free-standing, located in a clinic or located in a Hospital. Benefits under this section include allergy injections, Shingles vaccine and hearing exams in case of Injury or Sickness. Benefits for preventive services are described under Preventive Care Services in this section.	***PPO Network*** No	20%	Yes	Yes
	PPO Non-Network No	40%	Yes	Yes
	Out-of-Area No	20%	Yes	Yes

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Or Coinsurance Amount % Coinsurance is based on a percent of Eligible Expenses	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
22. Preventive Care Preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law: • evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force; • immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; • with respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and • with respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration. Preventive care Benefits defined under the Health Resources and Services Administration (HRSA) requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. Benefits for breast pumps also include the cost of purchasing one breast pump per Pregnancy in conjunction with childbirth. Benefits are only available if breast pumps are obtained from a DME	***PPO Network*** No ***PPO Non-Network*** No ***Out-of-Area*** No	0% 0% 0%	N/A N/A N/A	No No No

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Or Coinsurance Amount % Coinsurance is based on a percent of Eligible Expenses	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
provider or Physician. If more than one breast pump can meet your needs, Benefits are available only for the most cost effective pump. The Claims Administrator will determine the following: • which pump is the most cost effective; • whether the pump should be purchased or rented; • duration of a rental; and • timing of an acquisition.				
23. Professional Fees for Surgical and Medical Services Professional fees for surgical procedures and other medical care received in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility.	***PPO Network*** No	20%	Yes	Yes
	PPO Non-Network No	40%	Yes	Yes
	Out-of-Area No	20%	Yes	Yes
24. Prosthetic Devices Prosthetic devices that replace a limb or body part including: • Artificial limbs. • Artificial eyes. • Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998. If more than one prosthetic device can meet your functional needs, Benefits are available only for the most cost-effective prosthetic device. The prosthetic device must be ordered or provided by, or under the	***PPO Network*** No	20%	Yes	Yes
	PPO Non-Network No	40%	Yes	Yes
	Out-of-Area No	20%	Yes	Yes

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Or Coinsurance Amount % Coinsurance is based on a percent of Eligible Expenses	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
direction of a Physician. We provide Benefits for a single purchase, including repairs, of a type of prosthetic device. Benefits are provided for the replacement of each type of prosthetic device every five calendar years. At the Claims Administrator's discretion, prosthetic devices may be covered for damage beyond repair with normal wear and tear, when repair costs are less than the cost of replacement or when a change in the Covered Person's medical condition occurs sooner than the three year timeframe. Replacement of artificial limbs or any part of such devices may be covered when the condition of the device or part requires repairs that cost more than the cost of a replacement device or part.				
25. Reconstructive Procedures Reconstructive procedures - services are considered reconstructive procedures when a physical impairment exists and the primary purpose of the procedure is to improve or restore physiologic function for an organ or body part. By improving or restoring physiologic function it is meant that the target organ or body part is made to work better. An example of a reconstructive procedure is surgery on the inside of the nose so that a person's breathing can be improved or restored. Cosmetic Procedures - services are considered Cosmetic Procedures when they improve appearance without making an organ or body part work better. The fact that a person may suffer psychological consequences from the impairment does not classify surgery and other procedures done to relieve such consequences as a reconstructive procedure. Reshaping a nose with a prominent "bump" would be a good example of a Cosmetic Procedure because appearance would be improved, but there would be no effect on function like breathing. This Plan does not provide Benefits for Cosmetic Procedures.	***PPO Network*** Yes ***PPO Non-Network*** Yes ***Out-of-Area*** Yes	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services, and Prosthetic Devices. Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services, and Prosthetic Devices. Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services, and Prosthetic Devices.		

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Or Coinsurance Amount % Coinsurance is based on a percent of Eligible Expenses	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?

Some services are considered cosmetic in some circumstances and reconstructive in others. This means that there may be situations in which the primary purpose of the service is to make a body part work better, whereas in other situations, the purpose would be to improve appearance and function (such as vision) is not affected. A good example is upper eyelid surgery. At times, this procedure will improve vision, while on other occasions improvement in appearance is the primary purpose of the procedure.

Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry. Other services mandated by the Women's Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any Covered Health Service.

You can contact Personal Health Support at the toll free telephone number shown on your ID card, **1-866-249-7606**, for more information about Benefits for mastectomy-related services.

Notify Personal Health Support

Please remember that you should notify Personal Health Support five business days before receiving services. When you provide notification, Personal Health Support can verify that the service is a reconstructive procedure rather than a Cosmetic Procedure. Cosmetic Procedures are always excluded from coverage. If you don't notify Personal Health Support, Benefits will be reduced to 40% of Eligible Expenses.

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Or Coinsurance Amount % Coinsurance is based on a percent of Eligible Expenses	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
26. Rehabilitation Services - Outpatient Therapy Short-term outpatient rehabilitation services for: • Physical therapy. • Occupational therapy. • Speech therapy. • Pulmonary rehabilitation therapy. • Cardiac rehabilitation therapy. Rehabilitation services must be performed by a licensed therapy provider, under the direction of a Physician (when required by state law). Benefits are available only for rehabilitation services that are expected to result in significant physical improvement in your condition within two months of the start of treatment. Please note that we will pay Benefits for speech therapy only when the speech impediment or speech dysfunction results from Injury, Sickness, stroke, cancer, autism spectrum disorders or a Congenital Anomaly. Please note that the Plan excludes any type of therapy, service or supply for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring. ***Habilitative Services*** Benefits for habilitative services are subject to the limits of this section and are subject to the requirements stated below. Benefits are provided for habilitative services provided on an outpatient	***PPO Network*** No	20%	Yes	Yes
	PPO Non-Network No	40%	Yes	Yes
	Out-of-Area No	20%	Yes	Yes

basis for Covered Persons with a congenital, genetic, or early acquired disorder when both of the following conditions are met:

- the treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist, Physician, licensed nutritionist, licensed social worker or licensed psychologist.
- the initial or continued treatment must be proven and not Experimental or Investigational.

Benefits for habilitative services do not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and residential treatment are not habilitative services. A service that does not help the Covered Person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service. When the Covered Person reaches his/her maximum level of improvement or does not demonstrate continued progress under a treatment plan, a service that was previously habilitative is no longer habilitative.

The Plan may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow the Plan to substantiate that initial or continued medical treatment is needed and that the Covered Person's condition is clinically improving as a result of the habilitative service. When the treating provider anticipates that continued treatment is or will be required to permit the Covered Person to achieve demonstrable progress, we may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated.

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Or Coinsurance Amount % Coinsurance is based on a percent of Eligible Expenses	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?

For purposes of this benefit, the following definitions apply:

- "Habilitative services" means occupational therapy, physical therapy and speech therapy prescribed by the Covered Person's treating Physician pursuant to a treatment plan to develop a function not currently present as a result of a congenital, genetic, or early acquired disorder.
- A "congenital or genetic disorder" includes, but is not limited to, hereditary disorders.
- An "early acquired disorder" refers to a disorder resulting from Sickness, Injury, trauma or some other event or condition suffered by a Covered Person prior to that Covered Person developing functional life skills such as, but not limited to, walking, talking, or self-help skills.

Outpatient Rehabilitation Benefits are limited as follows:

Any combination of PPO Network and PPO Non-Network

- 30 visits of physical therapy per calendar year.
- 30 visits of occupational therapy per calendar year.
- 30 visits of speech therapy per calendar year.
- 20 visits of pulmonary rehabilitation therapy per calendar year.

Out-of Area

- 30 visits of physical therapy per calendar year.
- 30 visits of occupational therapy per calendar year.
- 30 visits of speech therapy per calendar year.
- 20 visits of pulmonary rehabilitation therapy per calendar year.

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Or Coinsurance Amount % Coinsurance is based on a percent of Eligible Expenses	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
• 20 visits of cardiac rehabilitation therapy per calendar year.	• 20 visits of cardiac rehabilitation therapy per calendar year.			
27. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for: • Services and supplies received during the Inpatient Stay. • Room and board in a Semi-private Room (a room with two or more beds). Any combination of **PPO Network and PPO Non-Network** Benefits are limited to 60 days per calendar year. **Out-of-Area Benefits** are limited to 60 days per calendar year. Please note that, in general, the intent of skilled nursing is to provide Benefits for Covered Persons who are convalescing from an Injury or illness that requires an intensity of care or a combination of skilled nursing, rehabilitation and facility services which are less than those of a general acute Hospital but greater than those available in the home setting. The Covered Person is expected to improve to a predictable level of recovery. Benefits are available when skilled nursing and/or rehabilitation services are needed on a daily basis. Accordingly, Benefits are NOT available when these services are required intermittently (such as physical therapy three	***PPO Network*** Yes ***PPO Non-Network*** Yes ***Out-of-Area*** Yes	***PPO Network*** 20% ***PPO Non-Network*** 40% ***Out-of-Area*** 20%	***PPO Network*** Yes ***PPO Non-Network*** Yes ***Out-of-Area*** Yes	***PPO Network*** Yes ***PPO Non-Network*** Yes ***Out-of-Area*** Yes

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Or Coinsurance Amount % Coinsurance is based on a percent of Eligible Expenses	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?

times a week).

Benefits are NOT available for custodial, domiciliary or maintenance care (including administration of enteral feeds) which, even if it is ordered by a Physician, is primarily for the purpose of meeting personal needs of the Covered Person or maintaining a level of function, as opposed to improving that function to an extent that might allow for a more independent existence.

(Custodial, domiciliary or maintenance care may be provided by persons without special skill or training. It may include, but is not limited to, help in getting in and out of bed, walking, bathing, dressing, eating and taking medication, as well as ostomy care, hygiene or incontinence care, and checking of routine vital signs.)

Notify Personal Health Support

Please remember that you must notify Personal Health Support as follows:

- For elective admissions: five business days before admission.
- For non-elective admission: within one business day or the same day of admission.
- For Emergency admissions: within two business days or the same day of admission, or as soon as is reasonably possible.

If you don't notify Personal Health Support, Benefits will be reduced to 40% of Eligible Expenses.

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Or Coinsurance Amount % Coinsurance is based on a percent of Eligible Expenses	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
28. Spinal Treatment, Chiropractic and Osteopathic Manipulative Therapy Benefits for Spinal Treatment include chiropractic and osteopathic manipulative therapy. Benefits for Spinal Treatment when provided by a Spinal Treatment provider in the provider's office. Benefits include diagnosis and related services and are limited to one visit and treatment per day. Please note that the Plan excludes any type of therapy, service or supply including, but not limited to spinal manipulations by a chiropractor or other doctor for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring. Any combination of **PPO Network and PPO Non-Network Benefits** for Spinal Treatment is limited to 20 visits per calendar year. **Out-of-Area Benefits** for Spinal Treatment is limited to 20 visits per calendar year.	***PPO Network*** No	20%	Yes	Yes
	PPO Non-Network No	40%	Yes	Yes
	Out-of-Area No	20%	Yes	Yes

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Or Coinsurance Amount % Coinsurance is based on a percent of Eligible Expenses	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
29. Substance Use Disorder Services Substance Use Disorder Services include those received on an inpatient basis in a Hospital or an Alternate Facility and those received on an outpatient basis in a provider's office or at an Alternate Facility. Benefits include the following services provided on either an inpatient or outpatient basis: • Diagnostic evaluations and assessment. • Treatment planning. • Referral services. • Medication management. • Individual, family, therapeutic group and provider-based case management. • Crisis intervention. • Detoxification (sub-acute/non-medical). Benefits include the following services provided on an inpatient basis: • Partial Hospitalization/Day Treatment. • Services at a Residential Treatment Facility. Benefits include Intensive Outpatient Treatment services provided on an outpatient basis. The MH/SUD Administrator determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis. You are encouraged to contact the MH/SUD Administrator for referrals	***PPO Network*** You must call the Mental Health/ Substance Use Disorder Administrator to receive the Benefits.	**Hospital – Inpatient Stay** 20% per Inpatient Stay.	Yes	Yes
		Physician's Office Services 20% per visit.	Yes	Yes
	PPO Non-Network You must call the Mental Health/ Substance Use Disorder Administrator to receive the Benefits.	**Hospital – Inpatient Stay** 40% per Inpatient Stay.	Yes	Yes
		Physician's Office Services 40% per visit.	Yes	Yes
	Out-of-Area You must call the Mental Health/ Substance Use Disorder Administrator to receive the Benefits.	**Hospital – Inpatient Stay** 20% per Inpatient Stay.	Yes	Yes
		Physician's Office Services 20% per visit.	Yes	Yes

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Or Coinsurance Amount % Coinsurance is based on a percent of Eligible Expenses	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?

to providers and coordination of care.

Special Substance Use Disorder Programs and Services
Special programs and services that are contracted under the MH/SUD Administrator may become available to you as part of your Substance Use Disorder Services benefit. The Substance Use Disorder Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of benefit use. Special programs or services provide access to services that are beneficial for the treatment of your Substance Use Disorder which may not otherwise be covered under this Plan. You must be referred to such programs through the MH/SUD Administrator, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such program or service is at the discretion of the Covered Person and is not mandatory.

Notification Required
Please remember that you must notify the MH/SUD Administrator to receive these Benefits. The MH/SUD Administrator phone number appears on your ID card. Without notification, Benefits will be reduced to 40% of Eligible Expenses.

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Or Coinsurance Amount % Coinsurance is based on a percent of Eligible Expenses	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
30. Transplantation Services Covered Health Services for the following organ and tissue transplants when ordered by a Physician. Benefits are available to the donor and the recipient when the recipient is covered under this Plan. The transplant must meet the definition of a Covered Health Service and cannot be Experimental, Investigational, or Unproven. Benefits are available for the transplants listed below. Personal Health Support notification is required for all transplant services. The service described under Transportation and Lodging below are Covered Health Services **ONLY** in connection with a transplant received at a Designated United Resource Network Facility. Examples of transplants for which Benefits are available include but are not limited to: • Bone marrow transplants (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy. Not all bone marrow transplants meet the definition of a Covered Health Service. The search for bone marrow/stem cell from a donor who is not biologically related to the patient is a Covered Health Service only for a transplant received at a Designated United Resource Network Facility. If a separate charge is made for a bone marrow/stem cell search, a Maximum Benefit of $25,000 is payable for all charges made in connection with the search. • Bone Marrow. • Peripheral Stem Cell. • Heart transplants. • Heart/lung transplants.	***PPO Network*** Yes ***PPO Non-Network*** Yes ***Out-of-Area*** Yes	20% 40% 20%	Yes Yes Yes	Yes Yes Yes

- Lung transplants.
- Kidney transplants.
- Kidney/pancreas transplants.
- Liver transplants.
- Liver/small bowel transplants.
- Pancreas transplants.
- Small bowel transplants.

Benefits for cornea transplants that are provided by a Physician at a Network Hospital are paid as if the transplant was received at a Designated United Resource Network Facility. We do not require that cornea transplants be performed at a Designated United Resource Network Facility in order for you to receive the highest level of Network Benefits.

Organ or tissue transplants or multiple organ transplants other than those listed above are excluded from coverage, unless determined by Personal Health Support to be a proven procedure for the involved diagnoses.

Under the Plan there are specific guidelines regarding Benefits for transplant services. Contact Personal Health Support at the toll free telephone number, **1-866-249-7606**, shown on your ID card for information about these guidelines.

Transportation and Lodging

Personal Health Support will assist the patient and family with travel and lodging arrangements only when services are received from a Designated United Resource Network Facility. Expenses for travel, and lodging for the transplant recipient and a companion are available under this Plan as follows:

- Transportation of the patient and one companion who is traveling on

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Or Coinsurance Amount % Coinsurance is based on a percent of Eligible Expenses	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
the same day(s) to and/or from the site of the transplant for the purposes of an evaluation, the transplant procedure or necessary post-discharge follow-up. • Eligible Expenses for lodging for the patient (while not confined) and one companion. Benefits are paid at a per diem rate of up to $50 for one person or up to $100 for two people. • Travel and lodging expenses are only available if the transplant recipient resides more than 50 miles from the Designated United Resource Network Facility. • If the patient is an Enrolled Dependent minor child, the transportation expenses of two companions will be covered and lodging expenses will be reimbursed up to the $100 per diem rate. There is a combined overall lifetime maximum Benefit of $10,000 per Covered Person for all transportation, and lodging expenses incurred by the transplant recipient and companion(s) and reimbursed under this Plan in connection with all transplant procedures. **Notify Personal Health Support** You must notify Personal Health Support as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't notify Personal Health Support, Benefits will be reduced to 40% of Eligible Expenses.				

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Or Coinsurance Amount % Coinsurance is based on a percent of Eligible Expenses	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
31. Urgent Care Center Services Covered Health Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services* earlier in this section.	***PPO Network*** No	20%	Yes	Yes
	PPO Non-Network No	40%	Yes	Yes
	Out-of-Area No	20%	Yes	Yes

Section 2: What's Not Covered--Exclusions

This section contains information about:

- How headings are used in this section.
- Medical services that are not covered. We call these Exclusions. It's important for you to know what services and supplies are not covered under the Plan.

How We Use Headings in this Section

To help you find specific exclusions more easily, we use headings. The headings group services, treatments, items, or supplies that fall into a similar category. Actual exclusions appear underneath headings. A heading does not create, define, modify, limit or expand an exclusion. All exclusions in this section apply to you.

Plan Exclusions

We will not pay or approve Benefits for any of the services, treatments, items or supplies described in this section, even if either of the following is true:

- It is recommended or prescribed by a Physician.
- It is the only available treatment for your condition.

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The services, treatments, items or supplies listed in this section are not Covered Health Services, except as may be specifically provided for in Section 1: Covered Health Services or through a Rider to the SPD.

A. Alternative Treatments

1. Acupressure.
2. Aromatherapy.
3. Hypnotism.
4. Massage Therapy.
5. Rolfing.
6. Other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.
7. Services received by a naturopath.
8. Holistic or homeopathic care.

B. Comfort or Convenience

1. Television.
2. Telephone.
3. Beauty/Barber service.
4. Guest service.
5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
   - —Air conditioners.
   - —Air purifiers and filters.
   - —Batteries and battery chargers.
   - —Dehumidifiers.
   - —Humidifiers.
6. Devices and computers to assist in communication and speech.

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7. Home remodeling to accommodate a health need (such as, but not limited to, ramps and swimming pools).

C. Dental

1. Dental care except as described in Section 1: What's Covered--Benefits under the heading *Dental Services - Accident Only*.
2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include all of the following:
   —Extraction, restoration and replacement of teeth.
   —Medical or surgical treatments of dental conditions.
   —Services to improve dental clinical outcomes.
3. Dental implants.
4. Dental braces.
5. Dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia.

   This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Plan, as identified in (Section 1: What's Covered--Benefits) under the heading *Dental Services - Accident Only*.
6. Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a Congenital Anomaly.

D. Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill.
2. Self-injectable medications.
3. Non-injectable medications given in a Physician's office except as required in an Emergency.

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4. Over the counter drugs and treatments.

E. Experimental, Investigational or Unproven Services

Experimental or Investigational Services and Unproven Services are excluded. The fact that an Experimental or Investigational Service or an Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

F. Foot Care

1. Except when needed for severe systemic disease:
   —Routine foot care (including the cutting or removal of corns and calluses).
   —Nail trimming, cutting, or debriding.
2. Hygienic and preventive maintenance foot care. Examples include the following:
   —Cleaning and soaking the feet.
   —Applying skin creams in order to maintain skin tone.
   —Other services that are performed when there is not a localized illness, Injury or symptom involving the foot.
3. Treatment of flat feet.
4. Treatment of subluxation of the foot.
5. Shoe orthotics.

G. Medical Supplies and Appliances

1. Devices used specifically as safety items or to affect performance in sports-related activities.

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2. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
   —Elastic stockings.
   —Ace bandages.
   —Gauze and dressings.
   —Syringes.
   —Diabetic test strips.
3. Orthotic appliances and devices that straighten or re-shape a body part, except as described in (Section 1: What's Covered--Benefits) under the heading *Durable Medical Equipment*. Examples of excluded orthotic appliances and devices include but are not limited to, foot orthotics or any braces available over the counter.
4. Cranial banding.
5. Tubings, nasal cannulas, connectors and masks are not covered except when used with Durable Medical Equipment (as described in Section 1: What's Covered--Benefits.

H. Mental Health/Substance Use Disorder

Exclusions listed directly below apply to services described under *Mental Health Services* and/or *Substance Use Disorder Services* as described in (Section 1: What's Covered--Benefits).

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. Services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance use disorders that, in the reasonable judgment of the MH/SUD Administrator, are any of the following:

To continue reading, go to right column on this page.

   — Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
   — Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
   — Not consistent with the MH/SUD Administrator's level of care guidelines or best practices as modified from time to time.
   — Not clinically appropriate for the patient's Mental Illness, Substance Use Disorder or condition based on generally accepted standards of medical practice and benchmarks.
3. Mental Health Services as treatments for V-code conditions as listed within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
4. Mental Health Services as treatment for a primary diagnosis of insomnia other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis.
4. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilias (sexual behavior that is considered deviant or abnormal).
5. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.
6. Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*.
7. Learning, motor skills and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

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8. Mental retardation and autism spectrum disorder as a primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
9. Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents for drug addiction.
10. Intensive behavioral therapies such as applied behavioral analysis for Autism Spectrum Disorders.

I. Nutrition

1. Megavitamin and nutrition based therapy.
2. Except as described in Section 1: What's Covered -- Benefits under *Nutritional Counseling,* nutritional counseling for either individuals or groups, including weight loss programs, health clubs and spa programs.
3. Enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk unless they are the only sole source of nutrition or unless they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU). Infant formula available over the counter is always excluded;
   - — foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes;
   - — oral vitamins and minerals;
   - — meals you can order from a menu, for an additional charge, during an Inpatient Stay; and
   - — other dietary and electrolyte supplements.

J. Physical Appearance

1. Cosmetic Procedures. See the definition in Section 10: Glossary of Defined Terms. Examples include:
   - —Pharmacological regimens, nutritional procedures or treatments.
   - —Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
   - —Skin abrasion procedures performed as a treatment for acne.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure.
   Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in Section 1: What's Covered--Benefits.
3. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation.
4. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
5. Wigs regardless of the reason for the hair loss.
6. Services received from a personal trainer.
7. Liposuction.

K. Providers

1. Services performed by a provider who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
2. Services performed by a provider with your same legal residence.
3. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services that are self-directed to a free-standing or Hospital-

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based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:

—Has not been actively involved in your medical care prior to ordering the service, or

—Is not actively involved in your medical care after the service is received.

This exclusion does not apply to mammography testing.

L. Reproduction

1. Health services and associated expenses for infertility treatments.
2. Surrogate parenting.
3. The reversal of voluntary sterilization.
4. Fees or direct payment to a donor for sperm or ovum donations.
5. Monthly fees for maintenance and/or storage of frozen embryos.

M. Services Provided under Another Plan

1. Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. This includes, but is not limited to, coverage required by workers' compensation, no-fault auto insurance, or similar legislation.

   If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.

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2. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
3. Health services while on active military duty.

N. Transplants

1. Health services for organ and tissue transplants, except those described in Section 1: What's Covered--Benefits when UnitedHealthcare determines the transplant to be appropriate according to UnitedHealthcare's transplant guidelines.
2. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs for removal are payable for a transplant through the organ recipient's Benefits under the Plan).
3. Health services for transplants involving mechanical or animal organs.
4. 5. Any multiple organ transplant not listed as a Covered Health Service under the heading *Transplantation Health Services* in Section 1: What's Covered--Benefits, unless determined by the Claims Administrator to be a proven procedure for the involved diagnoses.

O. Travel

1. Health services provided in a foreign country, unless required as Emergency Health Services.
2. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to covered services rendered at United Resource Networks participating programs or Designated Facilities may be reimbursed at our discretion.

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P. Vision (see separate Vision Benefit)

1. Purchase cost of eye glasses or contact lenses.
2. Fitting charge for eye glasses or contact lenses.
3. Eye exercise or vision therapy.
4. Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as radial keratotomy, laser, and other refractive eye surgery.

Q. All Other Exclusions

1. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in Section 10: Glossary of Defined Terms.
   This exclusion does not apply to breast pumps for which Benefits are provided under the Health Resources and Services Administration (HRSA) requirement.
2. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Plan when:
   - —Required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption.
   - —Related to judicial or administrative proceedings or orders.
   - —Conducted for purposes of medical research.
   - —Required to obtain or maintain a license of any type.
3. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone.

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4. Health services received after the date your coverage under the Plan ends, including health services for medical conditions arising before the date your coverage under the Plan ends.
5. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan.
6. In the event that a PPO Non-Network provider waives Copayments and/or the Annual Deductible for a particular health service, no Benefits are provided for the health service for which the Copayments and/or Annual Deductible are waived.
7. Charges in excess of Eligible Expenses or in excess of any specified limitation.
8. Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), when the services are considered to be medical or dental in nature, including oral appliances.
9. Speech therapy except as described under *Rehabilitation Services - Outpatient Therapy* in Section 1: What's Covered--Benefits.
10. Upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury dislocation, tumor or cancer. Orthognathic surgery (procedure to correct underbite or overbite), jaw alignment and treatment for the temporomandibular joint, except as a treatment of obstructive sleep apnea.
11. Non-surgical treatment of obesity, including morbid obesity.
12. Surgical treatment of obesity described under *Obesity Surgery* in Section 1: What's Covered--Benefits.
13. Growth hormone therapy.
14. Gender reassignment (sex transformation) surgery.
15. Custodial Care or maintenance care.
16. Domiciliary care.
17. Private Duty Nursing.

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18. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of service provided to a terminally ill person by a licensed hospice care agency for which Benefits are described under *Hospice Care* in Section 1: What's Covered--Benefits.
19. Rest cures.
20. Psychosurgery.
21. Treatment of benign gynecomastia (abnormal breast enlargement in males).
22. Medical and surgical treatment of excessive sweating (hyperhidrosis).
23. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
24. Appliances for snoring.
25. Any charges for missed appointments, room or facility reservations, completion of claim forms or record processing.
26. Any charges higher than the actual charge. The actual charge is defined as the provider's lowest routine charge for the service, supply or equipment.
27. Any charge for services, supplies or equipment advertised by the provider as free.
28. Any charges by a provider sanctioned under a federal program for reason of fraud, abuse or medical competency.
29. Any charges prohibited by federal anti-kickback or self-referral statutes.
30. Chelation therapy, except to treat heavy metal poisoning.
31. Any charges by a resident in a teaching Hospital where a faculty Physician did not supervise services.
32. Outpatient rehabilitation services, spinal treatment, manipulative treatment or supplies including, but not limited to spinal manipulations by a chiropractor or other doctor, for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring.
33. Spinal treatment, including chiropractic and osteopathic manipulative treatment, to treat an illness, such as asthma or allergies.
34. Speech therapy to treat stuttering, stammering, or other articulation disorders.
35. Breast reduction surgery that is determined to be a Cosmetic Procedure.

    This exclusion does not apply to breast reduction surgery which the Claims Administrator determines is requested to treat a physiologic functional impairment or to coverage required by the Women's Health and Cancer Right's Act of 1998 for which Benefits are described under *Reconstructive Procedures* in (Section 1: What's Covered--Benefits).
36. Foreign language and sign language services.
37. Panniculectomy, abdominoplasty, thighplasty, brachioplasty and mastopexy. This exclusion does not apply to *Reconstruction - Post-Mastectomy* in Section 1: What's Covered--Benefits.

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Section 3: Obtaining Benefits

This section includes information about:

- Benefits for Covered Health Services.
- Your responsibility for notification.
- Emergency Health Services.

Benefits for Covered Health Services

For the PPO Plan, Network Benefits are generally paid at a higher level than Non-Network Benefits. Network Benefits are payable for Covered Health Services which are any of the following:

- Provided by a Network Physician or other Network provider.
- Emergency Health Services.
- Covered Health Services that are described as Network Benefits in Section 1: What's Covered--Benefits.

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The following compares Network and Non-Network Benefits.

Comparison of PPO Network and PPO Non-Network Benefits

	Network	Non-Network
Benefits	A higher level of Benefits means less cost to you. See Section 1: What's Covered--Benefits.	A lower level of Benefits means more cost to you. See Section 1: What's Covered--Benefits.
Who Should Notify Personal Health Support	Notify *Personal Health Support* for certain Covered Health Services. Failure to notify will result in reduced Benefits or no Benefits. See *Must You Notify Personal Health Support?* column in Section 1.	
Who Should File Claims	Not required. The Claims Administrator pays Network providers directly.	You must file claims. See Section 5: How to File a Claim.
Outpatient Emergency Health Services	Emergency Health Services are always paid as a Network Benefit and are paid at the same Coinsurance whether you are in- or out of the Network. That means that if you seek Emergency care at a non-Network facility, you are required to meet the appropriate Annual Deductible and Coinsurance or pay any difference between Eligible Expenses and the amount billed by the provider.	

If you *are in the Out-of-Area Plan:*

Medical Benefits are payable for Covered Health Services that are provided by or under the direction of a Physician or other provider and are generally paid at the in-network benefit level even if the provider is not in the network.

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Whenever possible, however, you are encouraged to use in-network-providers. The cost of such services will be lower than for out-of-network providers. Therefore, your co-payment, which is a percentage of covered (eligible) charges, will be lower as well.

Provider Network

The Claims Administrator or its affiliate arranges for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees or employees of the Claims Administrator. It is your responsibility to select your provider.

The credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

You may request a directory of Network providers at no cost to you. Provider directories are always available on myuhc.com. However, before obtaining services you should always verify the Network status of a provider. A provider's status may change. You are responsible for verifying a provider's Network status prior to receiving services, even when you are referred by another Network Provider. You can verify the provider's status or request a provider directory by calling the Claims Administrator.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Network Benefits.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers agree to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider

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for only some products. Refer to your provider directory or contact the Claims Administrator for assistance.

Designated United Resource Network Facilities and Other Providers

If you have a medical condition that Personal Health Support believes needs special services, they may direct you to a Designated United Resource Network Facility or other provider chosen by them. If you require certain complex Covered Health Services for which expertise is limited, Personal Health Support may direct you to a non-Network facility or provider.

In both cases, Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated United Resource Network Facility or other provider chosen by Personal Health Support.

PPO Non-Network Benefits

PPO Non-Network Benefits are generally paid at a lower level than Network Benefits. PPO Non-Network Benefits are payable for Covered Health Services that are provided by PPO Non-Network Physicians or PPO Non-Network providers. PPO Non-Network Benefits are also payable for Covered Health Services that are provided at PPO Non-Network facilities.

UnitedHealth Premium[SM] Program

The UnitedHealth Premium program evaluates Network Physicians in certain specialties and facilities for specific services currently in UnitedHealthcare's Network. Physicians and facilities are evaluated first against quality criteria and then against efficiency of care criteria if quality criteria are met. You may obtain additional information regarding the UnitedHealth Premium program online at www.myuhc.com or by calling the number on the back of your ID card.

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Your Responsibility for Notification

You must notify Personal Health Support before getting certain Covered Health Services from PPO Network, PPO Non-Network and Out-of-Area providers. The details are shown in the *Must You Notify Personal Health Support?* column in Section 1: What's Covered--Benefits. If you fail to notify Personal Health Support, Benefits are reduced or denied.

Prior notification does not mean Benefits are payable in all cases. Coverage depends on the Covered Health Services that are actually given, your eligibility status, and any benefit limitations.

Personal Health Support

When you notify Personal Health Support as described above, they will work with you to implement the Personal Health Support process and to provide you with information about additional services that are available to you, such as disease management programs, health education, pre-admission counseling and patient advocacy.

If you are living with a chronic condition or dealing with complex health care needs, a primary nurse, referred to as a UnitedHealth MyNurse[SM], may be assigned to you to guide you through your treatment. This assigned nurse will answer questions, explain options, identify your needs, and may refer you to specialized care programs. The UnitedHealth MyNurse[SM] will provide you with their telephone number so you can call them with questions about your condition, or your overall health and well-being.

HealtheNotes[SM]

The Claims Administrator provides a service called HealtheNotes to help educate members and make suggestions regarding your medical care. HealtheNotes provides you and your Physician with suggestions regarding preventive care, testing or medications, potential interactions with medications you have been prescribed, and certain treatments. In addition, your HealtheNotes report may include health tips and other wellness information.

The Claims Administrator makes these suggestions through a software program that provides retrospective, claims-based identification of medical care. Through this process patients are identified whose care may benefit from suggestions using the established standards of evidence based medicine.

If your Physician identifies any concerns after reviewing his or her HealtheNotes report, he or she may contact you if he or she believes it to be appropriate. In addition, you may use the information in your report to engage your Physician in discussions regarding your health and the identified suggestions. Any decisions regarding your care, though, are always between you and your Physician.

If you have questions or would like additional information about this service, please call the number on the back of your ID card.

Emergency Health Services

We provide Benefits for Emergency Health Services when required for stabilization and initiation of treatment as provided by or under the direction of a Physician.

PPO Network Benefits are paid for Emergency Health Services, even if the services are provided by a non-Network provider.

- If you are confined in a non-Network Hospital after you receive Emergency Health Services, Personal Health Support must be notified within two business days or on the same day of admission if reasonably possible. Personal Health Support may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the non-Network Hospital after the date Personal Health Support

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decides a transfer is medically appropriate, PPO Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service.

- If you are admitted as an inpatient to a Network Hospital within 24 hours of receiving treatment for the same condition as an Emergency Health Service, you will not have to pay the Copayment for Emergency Health Services. The Copayment for an Inpatient Stay in a Network Hospital will apply instead.

  Note: Please note that the Copayment for Emergency Health Services will not be waived if you have been placed in an observation bed for the purpose of monitoring your condition, rather than being admitted as an inpatient in the Hospital. In this case, the Emergency Copayment will apply instead of the Copayment for an Inpatient Stay.

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Section 4: When Coverage Begins

This section includes information about:

- How to enroll.
- If you are hospitalized when this coverage begins.
- Who is eligible for coverage.
- When to enroll.
- When coverage begins.

How to Enroll

To enroll, the Eligible Person must complete an enrollment form. The Plan Administrator or your Employer will give the necessary forms to you along with instructions about submitting your enrollment form and any required contribution for coverage. We will not provide Benefits for health services that you receive before your effective date of coverage.

If You Are Hospitalized When Your Coverage Begins

If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, we will pay Benefits for Covered Health Services related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of the Plan.

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You should notify the Claims Administrator within 48 hours of the day your coverage begins, or as soon as is reasonably possible. PPO Network Benefits are available only if you receive Covered Health Services from Network Providers.

If You Are Eligible for Medicare

Your Benefits under the Plan may be reduced if you are eligible for Medicare but do not enroll in and maintain coverage under both Medicare Part A and Part B. **Employees and eligible Dependents** that are **eligible for Medicare** due to disability **must enroll in both parts of Medicare, Part A and Part B** as claims will be processed as if they were enrolled.

Your Benefits under the Plan may also be reduced if you are enrolled in a Medicare Advantage (Medicare Part C) plan but fail to follow the rules of that plan. Please see *Medicare Eligibility* in Section 9: General Legal Provisions for more information about how Medicare may affect your Benefits.

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Who is Eligible for Coverage

Who	Description	Who Determines Eligibility
Eligible Person	Eligible Person usually refers to an Employee employed by a SPONSORING EMPLOYER who meets the eligibility rules. When an Eligible Person actually enrolls, we refer to that person as a Covered Employee. For a complete definition of Eligible Person and Covered Employee, see Section 10: Glossary of Defined Terms. If both spouses are Eligible Persons, each may enroll as an Employee or be covered as an Enrolled Dependent of the other, but not both. Except as we have described in Section 4: When Coverage Begins, Eligible Persons may not enroll.	The Plan Administrator determines who is eligible to enroll under the Plan.
Dependent	Dependent generally refers to the Employee's spouse and children. When a Dependent actually enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see Section 10: Glossary of Defined Terms. Eligible Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under the Plan. If both parents of a Dependent child are enrolled as an Employee, only one parent may enroll the child as a Dependent.	The Plan Administrator determines who qualifies as a Dependent.

When to Enroll and When Coverage Begins

When to Enroll	Who Can Enroll	Begin Date
Initial Enrollment Period The Initial Enrollment Period is the first period of time when Eligible Persons can enroll.	Eligible Persons may enroll themselves and their eligible Dependents.	Coverage begins on the date identified by the Plan Administrator, if the Plan Administrator receives the completed enrollment form and any required contribution for coverage within 31 days of the date the Eligible Person becomes eligible to enroll.
Annual Open Enrollment Period	Eligible Persons may enroll themselves and their eligible Dependents.	The Plan Administrator determines the Open Enrollment Period. Coverage begins on the date identified by the Plan Administrator if the Plan Administrator receives the completed enrollment form and any required contribution.
New Eligible Persons	New Eligible Persons may enroll themselves and their eligible Dependents.	Coverage begins on the date of hire if the Plan Administrator receives the properly completed enrollment form and any required contribution for coverage within 31 days of the date the new Eligible Person becomes eligible to enroll and if the Employee pays any required contribution to the Plan Administrator for Coverage.

When to Enroll	Who Can Enroll	Begin Date
Adding New Eligible Dependents	Employees may enroll eligible Dependents who join their family because of any of the following events: • Birth. • Legal adoption. • Placement for adoption. • Marriage. • Legal guardianship. • Court or administrative order. • Registering a Domestic Partner	Coverage begins on the date of the event if the Plan Administrator receives the completed enrollment form and any required contribution for coverage within 31 days of the event that makes the new Dependent eligible. Newborn or adopted newborn children are automatically covered for 21 days following birth. A newborn or adopted child may be enrolled retroactively within 60 days of birth or adoption. If no additional premium is required, enrollment is not required as a condition of coverage, but claim reimbursement may be delayed until enrollment.
Special Enrollment Period An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period. A special enrollment period is not available to an Eligible Person and his or her eligible Dependents if coverage under the prior plan was terminated for cause, or because required contributions were not paid on a timely basis.	A special enrollment period applies: • to an Eligible Person and any eligible Dependents when one of the following events occurs: —Birth. —Legal adoption. —Placement for adoption. —Marriage. —Registering a Domestic Partner For an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period if the following are true:	**Event Takes Place** (for example, a birth or marriage or determination of eligibility for state subsidy). Unless otherwise noted under the "Who Can Enroll" column, coverage begins on the date of the event if the Plan Administrator receives the completed enrollment form and any required contribution within 31 days of the event. **Missed Initial Enrollment Period or Open Enrollment Period.** Coverage begins on the day immediately following the day coverage under the prior plan ends if the Plan Administrator receives the completed enrollment form and any required contribution within 31 days of the date coverage under the prior plan ended, except as otherwise noted.

When to Enroll	Who Can Enroll	Begin Date
An Eligible Person and/or Dependent does not need to elect COBRA continuation coverage to preserve special enrollment rights. Special enrollment is available to an Eligible Person and/or Dependent even if COBRA is elected.	• The Eligible Person and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the Initial Enrollment Period or Open Enrollment Period; and • Coverage under the prior plan ended because of any of the following: —Loss of eligibility (including, without limitation, legal separation, divorce or death). —The employer stopped paying the contributions. This is true even if the Eligible Person and/or Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer. —In the case of COBRA continuation coverage, the coverage ended. —The Eligible Person and/or Dependent no longer lives or works in an HMO service area if no other benefit option is available. —The Plan no longer offers benefits to a class of individuals that include the Eligible Person and/or Dependent. —An Eligible Person and/or Dependent incurs a claim that would exceed a lifetime limit on all benefits.	

When to Enroll	Who Can Enroll	Begin Date
CHIPRA - Special Enrollment Rights Expanded An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period	• The Eligible Person and/or Dependent had group health coverage sponsored by a governmental institution at the time they had an opportunity to enroll during the Initial Period or Open Enrollment Period.	Coverage begins on the first day of the month following the date the Plan Administrator receives the completed enrollment form providing the Plan Administrator receives the completed enrollment form within 60 days of the date of termination of that coverage.
	• The Eligible Person and/or Dependent was eligible under the Medicaid or a state child health insurance plan (CHIP), at the time they had an opportunity to enroll during the Initial Period or Open Enrollment Period.	Coverage begins on the first day of the month following the date the Plan Administrator receives the completed enrollment form providing the Plan Administrator receives the completed enrollment form within 60 days of the date of termination of that coverage.
	• The Eligible Person and/or Dependent gain eligibility for premium assistance subsidy under Medicaid or CHIP.	Coverage begins on the first day of the month following the date the Plan Administrator receives the completed enrollment form providing the Plan Administrator receives the completed enrollment form within 60 days from the date that the Eligible Person and/or Dependent is determined to be eligible for such premium assistance.

Section 5: How to File a Claim

This section provides you with information about:

- How and when to file a claim.
- If you receive Covered Health Services from a Network provider, you do not have to file a claim. We pay these providers directly.

Network Benefits

In general, if you receive Covered Health Services from a Network provider, the Claims Administrator will pay the Physician or facility directly. If a Network provider bills you for any Covered Health Service other than your Copayment, please contact the provider or call the Claims Administrator at the phone number on your ID card for assistance.

Keep in mind, you are responsible for meeting the Annual Deductible and paying any Copayment owed to a Network provider at the time of service, or when you receive a bill from the provider.

Non-Network Benefits

If you receive a bill for Covered Health Services from a Non-Network provider, you (or the provider if they prefer) must send the bill to the Claims Administrator for processing. To make sure the claim is processed promptly and accurately, a completed claim form must be attached and mailed to the Claims Administrator at the address on the back of your ID card.

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If Your Provider Does Not File Your Claim

You can obtain a claim form by visiting **myuhc.com**, calling the toll-free number on your ID card or contacting Us. If you do not have a claim form, simply attach a brief letter of explanation to the bill, and verify that the bill contains the information listed below. If any of these items are missing from the bill, you can include them in your letter:

- Your name and address.
- The patient's name, age and relationship to the Employee.
- The number as shown on your ID card.
- The name, address and tax identification number of the provider of the service(s).
- A diagnosis from the Physician.
- The date of service.
- An itemized bill from the provider that includes:
  - The Current Procedural Terminology (CPT) codes.
  - A description of, and the charge for, each service.
  - The date the Sickness or Injury began.
  - A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name and address of the other carrier(s).

Failure to provide all the information listed above may delay any reimbursement that may be due you.

The above information should be filed with us at the address on your ID card.

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After the Claims Administrator has processed your claim, you will receive payment for Benefits that the Plan allows. It is your responsibility to pay the Non-Network provider the charges you incurred, including any difference between what you were billed and what the Plan paid.

The Claims Administrator will pay Benefits to you unless:

- The provider notifies the Claims Administrator that you have provided signed authorization to assign Benefits directly to that provider.
- You make a written request for the Non-Network provider to be paid directly at the time you submit your claim.

The Claims Administrator will only pay Benefits to you or, with written authorization by you, your Provider, and not to a third party, even if your provider has assigned Benefits to that third party.

Health Statements

Each month in which the Claims Administrator processes at least one claim for you or a covered Dependent, you will receive a Health Statement in the mail. Health Statements make it easy for you to manage your family's medical costs by providing claims information in easy-to-understand terms.

If you would rather track claims for yourself and your covered Dependents online, you may do so at **www.myuhc.com**. You may also elect to discontinue receipt of paper Health Statements by making the appropriate selection on this site.

Explanation of Benefits (EOB)

You may request that the Claims Administrator send you a paper copy of an Explanation of Benefits (EOB) after processing the claim. The EOB will let you know if there is any portion of the claim you need to pay. If any claims are denied in whole or in part, the EOB will include the reason for the denial or partial payment. If you would like paper copies of the EOBs, you may call the toll-free number on your ID card to request them. You can also view and print all of your EOBs online at **myuhc.com**. See (Section 10: Glossary of Defined Terms) for the definition of Explanation of Benefits.

NOTE: Timely Filing of Claims - All claim forms must be submitted within 12 months after the date of service. Otherwise, the Plan will not pay any Benefits for that Eligible Expense, or Benefits will be reduced, as determined by Us. This 12-month requirement does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

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Section 6: Questions and Appeals

This section provides you with information to help you with the following:

- You have a question or concern about Covered Health Services or your Benefits.
- You are notified that a claim has been denied because it has been determined that a service or supply is excluded under the Plan and you wish to appeal such determination.

Claim Denials and Appeals

If Your Claim is Denied

If a claim for Benefits is denied in part or in whole, you may call the Claims Administrator at the number on your ID card before requesting a formal appeal. If the Claims Administrator cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

How to Appeal a Denied Claim

If you wish to appeal a denied pre-service request for Benefits, post-service claim or a rescission of coverage as described below, you or your authorized representative must submit your appeal in writing within 180 days of receiving the adverse benefit determination. You

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do not need to submit Urgent Care appeals in writing. This communication should include:

- The patient's name and ID number as shown on the ID card.
- The provider's name.
- The date of medical service.
- The reason you disagree with the denial.
- Any documentation or other written information to support your request.

You or your enrolled Dependent may send a written request for an appeal to:

UnitedHealthcare - Appeals
P.O. Box 30432
Salt Lake City, Utah 84130-0432

For Urgent Care requests for Benefits that have been denied, you or your provider can call the Claims Administrator at the toll-free number on your ID card to request an appeal.

Note: Types of claims - The timing of the claims appeal process is based on the type of claim you are appealing. If you wish to appeal a claim, it helps to understand whether it is an:

- Urgent care request for Benefits.
- Pre-service request for Benefits.
- Post-service claim.
- Concurrent claim.

Review of an Appeal

The Claims Administrator will conduct a full and fair review of your appeal. The appeal may be reviewed by:

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- An appropriate individual(s) who did not make the initial benefit determination.
- A health care professional with appropriate expertise who was not consulted during the initial benefit determination process.

Prior to issuing a determination on your appeal:

- You have the right to review your claim file and have access to and request copies of documents, records and other information that is relevant to your claim.
- You have the right to present evidence and testimony, including written comments, records and other information, relating to your claim.
- If any new or additional evidence is considered, relied upon or generated by the Claims Administrator in connection with your claim during the appeal, the Claims Administrator will provide you with such information, free of charge, prior to the issuance of its determination, and you will have reasonable opportunity to respond.
- If the Claims Administrator will uphold the denial based on a new or additional rationale, the Claims Administrator will provide you with such rationale, free of charge, prior to the issuance of its determination, and you will have reasonable opportunity to respond

Once the review is complete, if the Claims Administrator upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

The Claims Administrator must notify you of the appeal determination within 15 days after receiving the completed appeal for a pre-service denial and 30 days after receiving the completed post-service appeal.

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Note: Upon written request and free of charge, any Covered Persons may examine documents relevant to their claim and/or appeals and submit opinions and comments. The Claims Administrator will review all claims in accordance with the rules established by the U.S. Department of Labor. The Claims Administrator's decision will be final, unless you choose to make a voluntary appeal to the Plan Administrator or to request an external review.

Voluntary Appeal

If you are not satisfied with the first level appeal decision, you have the right, but are not required, to request a voluntary appeal to the Plan Administrator. You may also request an external review if your claim is based in whole or in part on a medical judgment or involves a rescission of coverage, as described below under *Federal External Review Program*. Note that if your claim is eligible for an external review, you may, but are not required, to request a voluntary appeal before you submit your request for an external review. If you do not request a voluntary appeal, your external review request must be submitted within 4 months from the receipt of the first level appeal decision.

If you decide to request a voluntary appeal, your voluntary appeal request must be submitted to the Plan Administrator within 60 days from the receipt of the first level appeal decision, or, if later, within 180 days following the initial adverse benefit determination.

If you request a voluntary appeal to the Plan Administrator, you will be provided the following:

- The opportunity to submit written comments, documents, records and other information that were submitted to the Claims Administrator in connection with your first level appeal.
- To receive upon request and free of charge reasonable access to, and copies of, all documents, records and other information

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relevant to your appeal that are sufficient to enable you to make an informed judgment about whether to submit a benefit dispute to the voluntary level of appeal.

- A review that takes into account all comments, documents, records and all other information relating to the claim submitted by you at the time of your first appeal to the Claims Administrator.
- A review conducted by the Plan Administrator that does not afford deference to the initial adverse benefit determination.
- The Plan Administrator will identify all medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination without regard to whether the advice was relied upon.
- Any health care professional engaged for purposes of a consultation with respect to your appeal will be an individual who is neither an individual who was consulted in connection with the initial adverse benefit determination nor a subordinate of such individual.

The voluntary appeal process is subject to the following terms and conditions:

- HEWT waives any right to assert that you have failed to exhaust administrative remedies because you did not elect to submit a benefit dispute to a voluntary appeal.
- The HEWT agrees that any statute of limitations or other defense based on timeliness is tolled during the time that your voluntary appeal is pending, but only if you comply with the requirements for a voluntary appeal. If you elect not to submit a voluntary appeal or do not comply with the requirements for submitting a voluntary appeal, the statute of limitations starts to run when the decision for your first level appeal to the Claims Administrator is issued.

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- You may elect to submit a benefit dispute to a voluntary appeal only after you have exhausted the appeals process to the Claims Administrator that is responsible for paying the claims;
- Upon request, the Plan Administrator will provide you with information relating to the voluntary level of appeal that is sufficient to enable you to make an informed judgment about whether to submit a benefit dispute to the voluntary level of appeal, including a statement that the your decision of whether to submit a benefit dispute to the voluntary level of appeal will have no effect on your rights to any other benefits under the plan and information about the applicable rules, your right to representation, the process for selecting the decision-maker, and the circumstances, if any, that may affect the impartiality of the decision-maker (e.g., any financial or personal interests in the result or any past or present relationship with any party to the review process).
- HEWT will not impose any fees or costs on you as part of the voluntary level of appeal.

You will receive notification of the Plan Administrator's decision on your appeal not later than 30 days after receipt by the Plan Administrator of your request for review unless the Plan Administrator determines that special circumstances (such as the need to hold a hearing) require an extension of time, in which you will be notified prior to the termination of the initial review period. Notice shall be provided to you in writing or electronically.

Federal External Review Program

If, after exhausting your internal appeals, you are not satisfied with the determination made by Hanford Employee Welfare Trust, or if Hanford Employee Welfare Trust fails to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an external review of Hanford Employee Welfare Trust's determination. The process is available at no charge to you.

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If one of the above conditions is met, you may request an external review of adverse benefit determinations based upon any of the following:

- clinical reasons;
- the exclusions for Experimental or Investigational Services or Unproven Services;
- rescission of coverage (coverage that was cancelled or discontinued retroactively); or
- as otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the toll-free number on your ID card or by sending a written request to the address set out in the determination letter. A request must be made within four months after the date you received Hanford Employee Welfare Trust's decision.

- An external review request should include all of the following:
- a specific request for an external review;
- the Covered Person's name, address, and insurance ID number;
- your designated representative's name and address, when applicable;
- the service that was denied; and
- any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization (IRO). The Claims Administrator has entered into agreements with three or more IROs that have agreed to perform such reviews. There are two types of external reviews available:

- a standard external review; and
- an expedited external review.

Standard External Review

A standard external review is comprised of all of the following:

- a preliminary review by the Claims Administrator of the request;
- a referral of the request by the Claims Administrator to the IRO; and
- a decision by the IRO.

Within the applicable timeframe after receipt of the request, the Claims Administrator will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

- is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided;
- has exhausted the applicable internal appeals process; and
- has provided all the information and forms required so that the Claims Administrator may process the request.

After the Claims Administrator completes the preliminary review, the Claims Administrator will issue a notification in writing to you. If the request is eligible for external review, the Claims Administrator will assign an IRO to conduct such review. The Claims Administrator will assign requests by either rotating claims assignments among the IROs or by using a random selection process.

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The IRO will notify you in writing of the request's eligibility and acceptance for external review. You may submit in writing to the IRO within ten business days following the date of receipt of the notice additional information that the IRO will consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted by you after ten business days.

The Claims Administrator will provide to the assigned IRO the documents and information considered in making Hanford Employee Welfare Trust's determination. The documents include:

- all relevant medical records;
- all other documents relied upon by Hanford Employee Welfare Trust; and
- all other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not previously provided, you may include this information with your external review request and the Claims Administrator will include it with the documents forwarded to the IRO.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by Hanford Employee Welfare Trust. The IRO will provide written notice of its determination (the "Final External Review Decision") within 45 days after it receives the request for the external review (unless they request additional time and you agree). The IRO will deliver the notice of Final External Review Decision to you and the Claims Administrator, and it will include the clinical basis for the determination.

Upon receipt of a Final External Review Decision reversing Hanford Employee Welfare Trust's determination, the Plan will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the Final External Review Decision is that payment or referral will not be made, the Plan will not be obligated to provide Benefits for the health care service or procedure.

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Expedited External Review

An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if you receive either of the following:

- an adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and you have filed a request for an expedited internal appeal; or
- a final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency services, but has not been discharged from a facility.

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Immediately upon receipt of the request, the Claims Administrator will determine whether the individual meets both of the following:

- is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
- has provided all the information and forms required so that the Claims Administrator may process the request.

After the Claims Administrator completes the review, the Claims Administrator will immediately send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, the Claims Administrator will assign an IRO in the same manner the Claims Administrator utilizes to assign standard external reviews to IROs. The Claims Administrator will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by Hanford Employee Welfare Trust. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to the Claims Administrator.

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You may contact the Claims Administrator at the toll-free number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

Timing of Appeals Determinations

Separate schedules apply to the timing of claims appeals, depending on the type of claim. There are three types of claims:

- Urgent Care request for Benefits- a request for Benefits provided in connection with Urgent Care services, as defined in (Section 10: Glossary of Defined Terms).
- Pre-Service request for Benefits - a request for Benefits which the Plan must approve or in which you must notify UnitedHealthcare before non-Urgent Care is provided.
- Post-Service - a claim for reimbursement of the cost of non-Urgent Care that has already been provided.

The tables below describe the time frames which you, the Claims Administrator and the Plan Administrator are required to follow.

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Urgent Care Request for Benefits*

Type of Request for Benefits or Appeal	Timing
If your request for Benefits is incomplete, the Claims Administrator must notify you within:	**24 hours**
You must then provide completed request for Benefits information to the Claims Administrator within:	**48 hours** after receiving notice of additional information required
The Claims Administrator must notify you of the benefit determination within:	**72 hours**
If the Claims Administrator denies your request for Benefits, you must appeal the adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
The Claims Administrator must notify you of the appeal decision within:	**72 hours** after receiving the appeal
*You do not need to submit Urgent Care appeals in writing. You should call the Claims Administrator as soon as possible to appeal an Urgent Care request for Benefits.	

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Pre-Service Request for Benefits

Type of Request for Benefits or Appeal	Timing
If your request for Benefits is filed improperly, the Claims Administrator must notify you within:	**5 days**
If your request for Benefits is incomplete, the Claims Administrator must notify you within:	**15 days**
You must then provide completed request for Benefits information to the Claims Administrator within:	**45 days**
If the Claims Administrator denies your initial request for Benefits, they must notify you of the denial:	
• If the initial request for Benefits is complete, within:	**15 days**
• After receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:	**15 days**
You must appeal the request for Benefits denial no later than:	**180 days** after receiving the denial
The Claims Administrator must notify you of the first level appeal decision within:	**15 days** after receiving the first level appeal
If you choose to file a voluntary appeal, you must appeal the first level appeal (file a voluntary appeal) within:	**60 days** after receiving the second level appeal decision
The Plan Administrator must notify you of the voluntary appeal decision within:	**30 days** after receiving the voluntary appeal

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Post-Service Claims

Type of Request for Benefits or Appeal	Timing
If your request for Benefits is incomplete, the Claims Administrator must notify you within:	**30 days**
You must then provide completed claim information to the Claims Administrator within:	**45 days** after receiving an extension notice
If the Claims Administrator denies your initial request for Benefits, they must notify you of the denial:	
• If the initial claim is complete, within:	**30 days**
• After receiving the completed claim (if the initial request for Benefits is incomplete), within:	**30 days**
You must appeal the claim denial no later than:	**180 days** after receiving the denial
The Claims Administrator must notify you of the first level appeal decision within:	**30 days** after receiving the first level appeal
If you choose to file a voluntary appeal, you must appeal the second level appeal (file a voluntary appeal) within:	**60 days** after receiving the second level appeal decision
The Plan Administrator must notify you of the voluntary appeal decision within:	**30 days** after receiving the voluntary appeal

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Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. The Claims Administrator will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

Limitation of Action

You cannot bring any legal action against Us or the Claims Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. If you want to bring a legal action against Us or the Claims Administrator, you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against Us or the Claims Administrator.

You cannot bring any legal action against Us or the Claims Administrator for any other reason unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring a legal action against

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Us or the Claims Administrator you must do so within three years of the date you are notified of our final decision on your appeal or you lose any rights to bring such an action against Us or the Claims Administrator.

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Section 7: Coordination of Benefits

This section provides you with information about:

- What you need to know when you have coverage under more than one plan.
- Definitions specific to Coordination of Benefit rules.
- Order of payment rules.

Coordination of Benefits (COB) applies to you if you are covered by more than one health benefits plan, including any one of the following:

- Another employer sponsored health benefits plan.
- A medical component of a group long-term care plan, such as skilled nursing care.
- No-fault or traditional "fault" type medical payment benefits or personal injury protection benefits under an auto insurance policy.
- Medical payment benefits under any premises liability or other types of liability coverage.
- Medicare or other governmental health benefit.

If coverage is provided under two or more plans, COB determines which plan is primary and which plan is secondary. The plan

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considered primary pays its benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining expenses may be paid under the other plan, which is considered secondary. The secondary plan may determine its benefits based on the benefits paid by the primary plan.

Determining Which Plan is Primary

If you are covered by two or more plans, the benefit payment follows the rules below in this order:

- This Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy.
- When you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first.
- A plan that covers a person as an employee pays benefits before a plan that covers the person as a dependent.
- If you are receiving COBRA continuation coverage under another employer plan, this Plan will pay Benefits first.
- Your dependent children will receive primary coverage from the parent whose birth date occurs first in a calendar year. If both parents have the same birth date, the plan that pays benefits first is the one that has been in effect the longest. This birthday rule applies only if:
  - — the parents are married or living together whether or not they have ever been married and not legally separated.
  - — a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.
- If two or more plans cover a dependent child of divorced or separated parents and if there is no court decree stating that one

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parent is responsible for health care, the child will be covered under the plan of:
  - — the parent with custody of the child; then
  - — the Spouse of the parent with custody of the child; then
  - — the parent not having custody of the child; then
  - — the Spouse of the parent not having custody of the child;
- Plans for active employees pay before plans covering laid-off or retired employees;
- The plan that has covered the individual claimant the longest will pay first. The expenses must be covered in part under at least one of the plans.
- Finally, if none of the above rules determines which plan is primary or secondary, the allowable expenses shall be shared equally between the plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the primary Plan.

When This Plan is Secondary

If this Plan is secondary, it determines the amount it will pay for a Covered Health Service by following the steps below.

- The Plan determines the amount it would have paid had it been the only plan involved.
- The Plan pays the entire difference between the allowable expense and the amount paid by the primary plan – as long as this amount is not more than the Plan would have paid had it been the only plan involved.
- At the end of the calendar year, the benefit reserve returns to zero. A new benefit reserve is created for each calendar year.

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The maximum combined payment you may receive from all plans cannot exceed 100% of the total allowable expense. See the textbox below for the definition of allowable expense.

What is an allowable expense?

For purposes of COB, an allowable expense is a health care expense that is covered at least in part by one of the health benefit plans covering you.

Determining the Allowable Expense When This Plan is Secondary

When this Plan is secondary, the allowable expense is the primary plan's Network rate. If the primary plan bases its reimbursement on reasonable and customary charges, the allowable expense is the primary plan's reasonable and customary charge. If both the primary plan and this Plan do not have a contracted rate, the allowable expense will be the greater of the two plans' reasonable and customary charges.

When a Covered Person Qualifies for Medicare

Determining Which Plan is Primary

To the extent permitted by law, this Plan will pay Benefits second to Medicare when you become eligible for Medicare, even if you don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:

- Employees with active current employment status age 65 or older and their Spouses age 65 or older.
- Individuals with end-stage renal disease, for a limited period of time.

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Determining the Allowable Expense When This Plan is Secondary

If this Plan is secondary to Medicare, the Medicare approved amount is the allowable expense, as long as the provider accepts Medicare. If the provider does not accept Medicare, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare) will be the allowable expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the total allowable expense.

If you are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, Benefits payable under this Plan will be reduced by the amount that would have been paid if you had been enrolled in Medicare.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine Benefits payable under this Coverage Plan and other Coverage Plans. The Claims Administrator may get the facts it needs from, or give them to, other organizations or persons for the purpose of applying these rules and determining Benefits payable under this Coverage Plan and other Coverage Plans covering the person claiming Benefits.

The Claims Administrator need not tell, or get the consent of, any person to do this. Each person claiming Benefits under this Coverage Plan must give us any facts we need to apply those rules and determine Benefits payable. If you do not provide us the information we need to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

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Overpayment and Underpayment of Benefits

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that the Plan Administrator should have paid. If this occurs, the Plan may pay the other plan the amount owed.

If the Plan pays you more than it owes under this COB provision, you should pay the excess back promptly. Otherwise, the Company may recover the amount in the form of salary, wages, or benefits payable under any Company-sponsored benefit plans, including this Plan. The Company also reserves the right to recover any overpayment by legal action or offset payments on future Eligible Expenses.

If the Plan overpays a health care provider, the Plan Administrator reserves the right to recover the excess amount, by legal action if necessary.

Refund of Overpayments

If the employer pays for Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to the employer if:

- all or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person;
- all or some of the payment the employer made exceeded the Benefits under the Plan; or
- all or some of the payment was made in error.

The refund equals the amount the Employer paid in excess of the amount that should have been paid under the Plan. If the refund is

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due from another person or organization, the Covered Person agrees to help the employer get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, the employer may reduce the amount of any future Benefits for the Covered Person that are payable under the Plan. The reductions will equal the amount of the required refund. The employer may have other rights in addition to the right to reduce future Benefits.

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Section 8: When Coverage Ends

This section provides you with information about all of the following:

- Events that cause coverage to end.
- The date your coverage ends.
- Continuation of coverage under federal law (COBRA).

General Information about When Coverage Ends

We may discontinue this Benefit Plan and/or all similar benefit plans at any time.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, we will still pay claims for Covered Health Services that you received before your coverage ended. However, once your coverage ends, Benefits are not provided for health services that you receive after coverage ended, even if the underlying medical condition occurred before your coverage ended.

An Enrolled Dependent's coverage ends on the date the Employee's coverage ends or sooner if the Employee chooses to end the Dependent's coverage or as otherwise set forth in this SPD.

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Events Ending Your Coverage

Coverage ends on the earliest of the dates specified in the following table:

Ending Event	What Happens
The Entire Plan Ends	Your coverage ends on the date the Plan ends. We are responsible for notifying you that your coverage has ended.
You Are No Longer Eligible	Unless an exception applies, your coverage ends on the date you are no longer eligible to be an Employee or Enrolled Dependent. Please refer to Section 10: Glossary of Defined Terms for a more complete definition of the terms "Eligible Person," "Employee," "Dependent," and "Enrolled Dependent." You may qualify for continuation coverage under federal law. See *Continuation Coverage under Federal Law (COBRA)* in this section. Exceptions under which your coverage may extend beyond employment include: Layoff and Displaced Worker Medical Benefit (DWMB). If you are laid off as a result of a reduction of force, you will be eligible for medical and vision coverage for you and your eligible dependents under the "Displaced Worker Medical Benefit Program", which is administered by the HEWT. You will be eligible for Displaced Worker coverage only if no other health coverage is available and all required contributions are paid. During the first year, contributions are the same as required of an active employee. During the second year, you must pay 50% of the DWMB rate for medical/vision. During the third year and thereafter, you must pay 100% of the DWMB rate for medical/vision. You will receive the DWMB instead of any medical or vision continuation coverage under COBRA. The Displaced Worker Medical Benefit Program does not provide dental coverage so you will be eligible for COBRA continuation coverage for dental. Disability. If you become disabled and qualify for disability benefits under your Employer's short-term or long-term disability program (or state industrial insurance), coverage for you and your eligible Dependents may be continued for the duration of the disability, until a dependent no longer qualifies as such, or until you retire, whichever first occurs. You must pay all required contributions.

Ending Event	What Happens
	Death. If you die, coverage for your eligible Dependents will continue for a period of one year. The required contributions are waived. If at the date of your death you have attained age 55 and have 10 or more years of vesting service, your eligible Dependents may elect to continue coverage beyond one year (this does not apply to Employees newly hired after January 1, 2004). The election must be in writing and within 31 calendar days after coverage would otherwise end. Coverage is dependent upon payment of required contributions. Coverage ends upon the earlier of failure to make the required contributions or remarriage of a spouse. The remarriage of a spouse does not render other eligible Dependents ineligible. Coverage for a Dependent will end when the Dependent no longer meets the eligibility criteria to qualify as a Dependent. This period of coverage will be credited towards satisfying the maximum coverage provided under COBRA discussed below. Family and Medical Leave. If you are on an approved FMLA leave you can continue health benefits. Contact the HEWT Benefit Administration for specifics. Military Leave. See *Uniformed Services Employment and Reemployment Rights Act* in this section. Other Leaves. If you are on an unpaid leave, coverage may be continued, provided you pay the required contributions.
The Claims Administrator Receives Notice to End Coverage	Your coverage ends on the date the Claims Administrator receives written notice from us (i.e., the HEWT or your employer), instructing the Claims Administrator to end your coverage, or the date requested in the notice, if later.
Employee Retires	Your coverage ends on the last day of the month prior to your retirement effective date with a Sponsoring Employer. However, you may qualify for continuation coverage under federal law. See *Continuation Coverage under Federal Law (COBRA)* in this section. In addition, you may qualify for health coverage in retirement under the Hanford Employee Welfare Trust Retiree Medical Plan. For information on the eligibility requirements, go to the "Plan Document and Administrative Information – Hanford Retiree Welfare Benefit Plans.
Failure to Pay	You failed to pay a required contribution.

Other Events Ending Your Coverage

When any of the following happen, we will provide prior written notice to the Employee that coverage will end on the date identified in the notice if:

Ending Event	What Happens
Fraud, Misrepresentation or False Information	The Employee commits an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact. Examples include, but are not limited to, false information relating to another person's eligibility or status as a Dependent.
Threatening Behavior	You committed acts of physical or verbal abuse that pose a threat to our staff, the Claims Administrator's staff, a provider, or other Covered Persons.

Coverage for a Handicapped Child

Coverage for an Enrolled Dependent child who is not able to be self-supporting because of mental retardation or a physical handicap will not end just because the child has reached a certain age. We will extend the coverage for that child beyond the limiting age if both of the following are true regarding the Enrolled Dependent child:

- Is not able to be self-supporting because of mental retardation or physical handicap.
- Depends mainly on the Employee for support.

Coverage will continue as long as the Enrolled Dependent is incapacitated and dependent unless coverage is otherwise terminated in accordance with the terms of the Plan.

We will ask you to furnish the Claims Administrator with proof of the child's incapacity and dependency within 31 days of the date coverage would otherwise have ended because the child reached a certain age. Before the Claims Administrator agrees to this extension of coverage for the child, the Claims Administrator may require that a Physician chosen by us examine the child. We will pay for that examination.

The Claims Administrator may continue to ask you for proof that the child continues to meet these conditions of incapacity and dependency. Such proof might include medical examinations at our expense. However, we will not ask for this information more than once a year.

If you do not provide proof of the child's incapacity and dependency within 31 days of the Claims Administrator's request as described above, coverage for that child will end.

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Continuation of Coverage

If your coverage ends under the Plan, you may be entitled to elect continuation coverage (coverage that continues on in some form) in accordance with federal law.

Continuation coverage under COBRA (the federal Consolidated Omnibus Budget Reconciliation Act) is available only to Plans that are subject to the terms of COBRA. You can contact your Plan Administrator to determine if we are subject to the provisions of COBRA.

If you selected continuation coverage under a prior plan which was then replaced by coverage under this Plan, continuation coverage will end as scheduled under the prior plan or in accordance with the terminating events listed below, whichever is earlier.

Continuation Coverage under Federal Law (COBRA)

Much of the language in this section comes from the federal law that governs continuation coverage. You should call your Plan Administrator if you have questions about your right to continue coverage.

In order to be eligible for continuation coverage under federal law, you must meet the definition of a "Qualified Beneficiary". A Qualified Beneficiary is any of the following persons who was covered under the Plan on the day before a qualifying event:

- An Employee.
- An Employee's Enrolled Dependent, including with respect to the Employee's children, a child born to or placed for adoption with the Employee during a period of continuation coverage under federal law.
- An Employee's former spouse.

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Qualifying Events for Continuation Coverage under COBRA

If the coverage of a Qualified Beneficiary would ordinarily terminate due to one of the following qualifying events, then the Qualified Beneficiary is entitled to continue coverage. The Qualified Beneficiary is entitled to elect the same coverage that she or he had on the day before the qualifying event.

The qualifying events with respect to an employee who is a Qualified Beneficiary are:

A. Termination of employment with us, for any reason other than gross misconduct and
B. Reduction in the Employee's hours of employment.

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With respect to an Employee's spouse or Dependent child who is a Qualified Beneficiary, the qualifying events are:

A. Termination of the Employee's employment (for reasons other than the Employee's gross misconduct); or
B. Reduction in the Employee's hours of employment; or
C. Death of the Employee; or
D. Divorce or legal separation from the covered Employee; or
E. Loss of eligibility by an Enrolled Dependent who is a child; or
F. Entitlement of the Employee to Medicare benefits; or.
G. The Plan Sponsor's commencement of a bankruptcy, under Title 11, United States Code. This is also a qualifying event for any retired Employee and his or her Enrolled Dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

Notification Requirements and Election Period for Continuation Coverage under COBRA

Notification Requirements for Qualifying Event

The Employee or other Qualified Beneficiary must notify the Plan Administrator within 60 days of the latest of the date of the Employee's divorce, legal separation or an Enrolled Dependent's loss of eligibility as an Enrolled Dependent; the date the Qualified Beneficiary would lose coverage under the Plan; or the date on which the Qualified Beneficiary is informed of his or her obligation to provide notice and the procedures for providing such notice. An Employee or other Qualified Beneficiary must also notify the Plan Administrator when a qualifying event occurs that will extend continuation coverage.

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If the Employee or other Qualified Beneficiary fails to notify the Plan Administrator of these events within the 60 day period, the Plan Administrator is not obligated to provide continued coverage to the affected Qualified Beneficiary. If an Employee is continuing coverage under federal law, the Employee must notify the Plan Administrator within 60 days of the birth or adoption of a child.

Notification Requirements for Disability Determination or Change in Disability Status

The Employee or other Qualified Beneficiary must notify the Plan Administrator as described under "COBRA Terminating Events" in this section.

The notice requirements will be satisfied by providing written notice to the Plan Administrator at the address stated in Attachment II. The contents of the notice must be such that the Plan Administrator is able to determine the covered employee and qualified beneficiary(ies), the qualifying event or disability, and the date on which the qualifying event occurred.

None of the notice requirements will be enforced if the Employee or other Qualified Beneficiary is not informed of his or her obligations to provide such notice.

After providing notice to the Plan Administrator, the Qualified Beneficiary shall receive the continuation coverage and election notice. Continuation must be elected by the later of 60 days after the qualifying event occurs; or 60 days after the Qualified Beneficiary receives notice of the continuation right from the Plan Administrator.

The Qualified Beneficiary's initial premium due to the Plan Administrator must be paid on or before the 45th day after electing continuation.

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Trade Act of 2002

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain Employees who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or 'alternative trade adjustment assistance' under a federal law called the Trade Act of 1974. These Employees are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

If an Employee qualifies or may qualify for assistance under the Trade Act of 1974, he or she should contact the Plan Administrator for additional information. The Employee must contact the Plan Administrator promptly after qualifying for assistance under the Trade Act of 1974 or the Employee will lose his or her special COBRA rights. COBRA coverage elected during the special second election period is not retroactive to the date that Plan coverage was lost, but begins on the first day of the special second election period.

COBRA Terminating Events

COBRA continuation coverage under the Plan will end on the earliest of the following dates:

A. Eighteen months from the date of the qualifying event, if the Qualified Beneficiary's coverage would have ended because the Employee's employment was terminated or hours were reduced (i.e., qualifying event A).

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If a Qualified Beneficiary is determined to have been disabled under the Social Security Act at anytime within the first 60 days of continuation coverage for qualifying event A, then the Qualified Beneficiary may elect an additional 11 months of continuation coverage (for a total of 29 months of continued coverage) subject to the following conditions: (i) notice of such disability must be provided within the latest of 60 days after a). the determination of the disability, b). the date of the qualifying event, c). the date the Qualified Beneficiary would lose coverage under the Plan, and in no event later than the end of the first 18 months; (ii) the Qualified Beneficiary must agree to pay any increase in the required premium for the additional 11 months. If the Qualified Beneficiary entitled to the 11 months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional 11 months of continuation coverage. Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

B. Thirty-six months from the date of the qualifying event for an Enrolled Dependent whose coverage ended because of the death of the Employee, divorce or legal separation of the Employee, loss of eligibility by an Enrolled Dependent who is a child (i.e. qualifying events C, D, or E).

C. With respect to Qualified Beneficiaries, and to the extent that the Employee was entitled to Medicare prior to the qualifying event:

   i. Eighteen months from the date of the Employee's termination of employment or work hours being reduced; or

   ii. Thirty-six months from the date of the Employee's Medicare entitlement, if a second qualifying event (that was due to

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either the Employee's termination of employment or the Employee's work hours being reduced), occurs prior to the expiration of the eighteen months.

D. With respect to Qualified Beneficiaries, and to the extent that the Employee became entitled to Medicare subsequent to the qualifying event:
   i. Thirty-six months from the date of the Employee's termination of employment or work hours being reduced (first qualifying event), if:
      a. the Employee's Medicare entitlement occurs within the eighteen month continuation period; and
      b. if absent the first qualifying event, the Medicare entitlement would have resulted in a loss of coverage for the Qualified Beneficiary under the group health plan.
E. The date coverage terminates under the Plan for failure to make timely payment of the premium.
F. The date, after electing continuation coverage, that coverage is first obtained under any other group health plan. If such coverage contains a limitation or exclusion with respect to any preexisting condition, continuation shall end on the date such limitation or exclusion ends. The other group health coverage shall be primary for all health services except those health services that are subject to the pre-existing condition limitation or exclusion.
G. The date, after electing continuation coverage, that the Qualified Beneficiary first becomes entitled to Medicare, except that this shall not apply in the event that coverage was terminated because the Plan Sponsor filed for bankruptcy (i.e. qualifying event G.). If the Qualified Beneficiary was entitled to continuation because the Plan Sponsor filed for bankruptcy, (i.e. qualifying event G.) and the retired Employee dies during the continuation period, then the other Qualified Beneficiaries shall be entitled to continue coverage for thirty-six months from the date of the Employee's death.
H. The date the entire Plan ends.
I. The date coverage would otherwise terminate under the Plan as described in this section under the heading *Events Ending Your Coverage*.

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Coverage Expires

When COBRA continuation coverage expires after 18, 29 or 36 months, an individual may have the opportunity to enroll in an individual conversion health plan by the Health Plan provided such option is otherwise generally available to similarly situated non-COBRA beneficiaries under the group health plan.

Continuation coverage for Qualified Beneficiaries whose continuation coverage terminates because the Employee becomes entitled to Medicare may be extended for an additional period of time. Such Qualified Beneficiaries should contact the Plan Administrator for information regarding the continuation period.

Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy for your records of any notices you send to the Plan Administrator.

Uniformed Services Employment and Reemployment Rights Act

An Employee who is absent from employment for more than 30 days by reason of service in the Uniformed Services may elect to continue Plan coverage for the Employee and the Employee's eligible Dependents in accordance with the Uniformed Services

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Employment and Reemployment Rights Act of 1994, as amended (USERRA).

The terms "Uniformed Services" or "Military Service" mean the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

If qualified pursuant to continue coverage pursuant to the USERRA, Employees may elect to continue coverage under the Plan by notifying the Plan Administrator in advance, and providing payment of any required contribution for the health coverage. This may include the amount the Employer normally pays on an Employee's behalf. If an Employee's Military Service is for a period of time less than 31 days, the Employee may not be required to pay more than the regular contribution amount, if any, for continuation of health coverage.

An Employee may continue Plan coverage under USERRA for up to the lesser of:

- The 24 month period beginning on the date of the Employee's absence from work; or
- The day after the date on which the Employee fails to apply for, or return to, a position of employment.

Regardless of whether an Employee continues health coverage, if the Employee returns to a position of employment, the Employee's health coverage and that of the Employee's eligible Dependents will be reinstated under the Plan. No exclusions or waiting period may be imposed on an Employee or the Employee's eligible Dependents in connection with this reinstatement, unless a Sickness or Injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

You should call the Plan Administrator if you have questions about your rights to continue health coverage under USERRA.

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Section 9: General Legal Provisions

This section provides you with information about:
- General legal provisions concerning your Plan.

Plan Document

This Summary Plan Description presents an overview of your Benefits. In the event of any discrepancy between this Summary Plan Description and the official Plan Document, the Plan Document shall govern.

Relationship with Providers

The relationships between us, the Claims Administrator, and Network providers are solely contractual relationships between independent contractors. Network providers are not our agents or Employees. Nor are they agents or Employees of the Claims Administrator. Neither we nor any of our Employees are agents or Employees of Network providers. Neither we nor the Claims Administrator are liable for any act or omission of any provider.

We do not provide health care services or supplies, nor do we practice medicine. Instead, we pay Benefits. Network providers are independent practitioners who run their own offices and facilities. The credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

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The Claims Administrator is not considered to be an employer or Plan Administrator for any purpose with respect to the administration or provision of Benefits under this Plan.

The Plan Administrator is solely responsible for all of the following:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of Benefits.
- Notifying you of the termination or modifications to the Plan.

Your Relationship with Providers

The relationship between you and any provider is that of provider and patient.

- You are responsible for choosing your own provider.
- You must decide if any provider treating you is right for you. This includes Network providers you choose and providers to whom you have been referred.
- You must decide with your provider what care you should receive.
- Your provider is solely responsible for the quality of the services provided to you.

The relationship between you and us is that of employer and Employee, Dependent or other classification as defined in the Plan.

Incentives to Providers

The Claims Administrator pays Network providers through various types of contractual arrangements, some of which may include financial incentives to promote the delivery of health care in a cost

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efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction, and/or cost effectiveness.
- Capitation - a group of Network providers receives a monthly payment from the Claims Administrator for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

The methods used to pay specific Network providers may vary. From time to time, the payment method may change. If you have questions about whether your Network provider's contract includes any financial incentives, we encourage you to discuss those questions with your provider. You may also contact the Claims Administrator at the telephone number, **1-866-249-7606**, shown on your ID card. They can advise whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed.

Incentives to You

Sometimes the Claims Administrator may offer incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but we recommend that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. Contact the Claims Administrator if you have any questions.

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Rebates and Other Payments

We and the Claims Administrator may receive rebates for certain drugs that are administered to you in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet your Annual Deductible. We and the Claims Administrator do not pass these rebates on to you, nor are they applied to your Annual Deductible or taken into account in determining your Copayments.

Interpretation of Benefits

We and the Claims Administrator have sole and exclusive discretion to do all of the following:

- Interpret Benefits under the Plan.
- Interpret the other terms, conditions, limitations and exclusions of the Plan, including this SPD and any Riders and Amendments.
- Make factual determinations related to the Plan and its Benefits.

We and the Claims Administrator may delegate this discretionary authority to other persons or entities who provide services in regard to the administration of the Plan.

In certain circumstances, for purposes of overall cost savings or efficiency, we may, in our sole discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that we do so in any particular case shall not in any way be deemed to require us to do so in other similar cases.

Administrative Services

We may, in our sole discretion, arrange for various persons or entities to provide administrative services in regard to the Plan, such as claims processing. The identity of the service providers and the

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nature of the services they provide may be changed from time to time in our sole discretion. We are not required to give you prior notice of any such change, nor are we required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

Amendments to the Plan

Although we expect to continue the Plan indefinitely, we reserve the right, to discontinue, alter or modify the Plan in whole or in part, at any time and for any reason, at our sole discretion.

Our decision to terminate or amend a Plan may be due to changes in federal or state laws governing employee benefits, the requirements of the Internal Revenue Code or Employee Retirement Income Security Act of 1974 (ERISA), or any other reason. A plan change may transfer plan assets and debts to another plan or split a plan into two or more parts. If we do change or terminate a plan, we may decide to set up a different plan providing similar or different benefits.

If this Plan is terminated, Covered Persons will not have the right to any other Benefits from the Plan, other than for those claims incurred prior to the date of termination, or as otherwise provided under the Plan. In addition, if the Plan is amended, Covered Persons may be subject to altered coverage and Benefits.

The amount and form of any final benefit you receive will depend on any Plan document or contract provisions affecting the Plan and our decisions. After all Benefits have been paid and other requirements of the law have been met, certain remaining Plan assets will be turned over to us and others as may be required by any applicable law.

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Clerical Error

If a clerical error or other mistake occurs, that error does not create a right to Benefits. These errors include, but are not limited to, providing misinformation on eligibility or Benefit coverages or entitlements. The terms of this Plan may not be amended by oral statements made by the Plan Sponsor, the Plan Administrative Committee, the Claims Administrator, or any other person. In the event an oral statement conflicts with any term of the Plan, the Plan terms will control. It is your responsibility to confirm the accuracy of statements made by us or our designees, including the Claims Administrator, in accordance with the terms of this SPD and other Plan documents.

Information and Records

We and the Claims Administrator may use your individually identifiable health information to administer the Plan and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. We and the Claims Administrator may request additional information from you to decide your claim for Benefits. We and the Claims Administrator will keep this information confidential. We and the Claims Administrator may also use your de-identified data for commercial purposes, including research, as permitted by law. By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish us or the Claims Administrator with all information or copies of records relating to the services provided to you. We and the Claims Administrator have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled eligible Dependents whether or not they have signed the Employee's enrollment form. We and the Claims Administrator agree that such information and records will be considered confidential.

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We and the Claims Administrator have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as we are required to do by law or regulation. During and after the term of the Plan, we, the Claims Administrator, and our related entities may use and transfer the information gathered under the Plan in a de-identified format for commercial purposes, including research and analytic purposes.

For complete listings of your medical records or billing statements we recommend that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from the Claims Administrator, they also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, we and the Claims Administrator will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Our designees have the same rights to this information as the Plan Administrator.

Examination of Covered Persons

In the event of a question or dispute regarding your right to Benefits, we may require that a Physician of our choice examine you at our expense.

Workers' Compensation not Affected

Benefits provided under the Plan do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

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Medicare Eligibility

Benefits under the Plan are not intended to supplement any coverage provided by Medicare. Nevertheless, in some circumstances Covered Persons who are eligible for or enrolled in Medicare may also be enrolled under the Plan.

If you are eligible for or enrolled in Medicare, please read the following information carefully.

If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under the Plan), you **should** enroll for and maintain coverage under both Medicare Part A and Part B. If you don't enroll and maintain that coverage, and if we are the secondary payer as described in Section 7: Coordination of Benefits, we will pay Benefits under the Plan as if you were covered under both Medicare Part A and Part B. As a result, you will be responsible for the costs that Medicare would have paid and you will incur a larger out-of-pocket cost.

If you are enrolled in a Medicare Advantage (Medicare Part C) Plan on a primary basis (Medicare pays before Benefits under the Plan), you **should** follow all rules of that Plan that require you to seek services from that Plan's participating providers. When we are the secondary payer, we will pay any Benefits available to you under the Plan as if you had followed all rules of the Medicare Advantage Plan. You will be responsible for any additional costs or reduced Benefits that result from your failure to follow these rules, and you will incur a larger out-of-pocket cost.

Subrogation and Reimbursement

The Plan has a right to subrogation and reimbursement.

Subrogation applies when the plan has paid Benefits on your behalf for a Sickness or Injury for which a third party is alleged to be

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responsible. The right to subrogation means that the Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the Benefits that the Plan has paid that are related to the Sickness or Injury for which a third party is alleged to be responsible.

Subrogation - Example
Suppose you are injured in a car accident that is not your fault, and you receive Benefits under the Plan to treat your injuries. Under subrogation, the Plan has the right to take legal action in your name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those Benefits.

The right to reimbursement means that if a third party causes or is alleged to have caused a Sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100% of any Benefits you received for that Sickness or Injury.

Reimbursement - Example
Suppose you are injured in a boating accident that is not your fault, and you receive Benefits under the Plan as a result of your injuries. In addition, you receive a settlement in a court proceeding from the individual who caused the accident. You must use the settlement funds to return to the plan 100% of any Benefits you received to treat your injuries.

The following persons and entities are considered third parties:

- a person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages;
- any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages;

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- the Plan Sponsor (for example workers' compensation cases);
- any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators; and
- any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Plan in protecting its legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
  - notifying the Plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable;
  - providing any relevant information requested by the Plan;
  - signing and/or delivering such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement claim;
  - responding to requests for information about any accident or injuries;
  - making court appearances;
  - obtaining the Plan's consent or its agents' consent before releasing any party from liability or payment of medical expenses; and
  - complying with the terms of this section.

  Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate your Benefits, deny future Benefits, take legal action against you,

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and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

- The Plan has a first priority right to receive payment on any claim against a third party before you receive payment from that third party. Further, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to Hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from the Plan's recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights.
- Benefits paid by the Plan may also be considered to be Benefits advanced.
- If you receive any payment from any party as a result of Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you shall hold those funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the Benefits the Plan has paid.
- The Plan's rights to recovery will not be reduced due to your own negligence.
- Upon the Plan's request, you will assign to the Plan all rights of recovery against third parties, to the extent of the Benefits the Plan has paid for the Sickness or Injury.
- The Plan may, at its option, take necessary and appropriate action to preserve its rights under these subrogation provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party and filing suit in your name, which does not obligate the Plan in any way to pay you part of any recovery the Plan might obtain.
- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries.

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- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If a third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.
- The Plan and all Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

Right of Recovery

The Plan also has the right to recover benefits it has paid on you or your Dependent's behalf that were:

- made in error;
- due to a mistake in fact;
- advanced during the time period of meeting the calendar year Deductible; or
- advanced during the time period of meeting the Out-of-Pocket Maximum for the calendar year.

Benefits paid because you or your Dependent misrepresented facts are also subject to recovery.

If the Plan provides a Benefit for you or your Dependent that exceeds the amount that should have been paid, the Plan will:

- require that the overpayment be returned when requested, or
- reduce a future benefit payment for you or your Dependent by the amount of the overpayment.

If the Plan provides an advancement of benefits to you or your Dependent during the time period of meeting the Deductible and/or meeting the Out-of-Pocket Maximum for the calendar year, the Plan will send you or your Dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover Benefits it has advanced by:

- submitting a reminder letter to you or a covered Dependent that details any outstanding balance owed to the Plan; and
- conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to the Plan.

Overpayment and Underpayment of Benefits

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that the Claims Administrator should have paid. If this occurs, the Plan may pay the other plan the amount owed.

If the Plan pays you more than it owes under the Coordination of Benefits provision, you should pay the excess back promptly.

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Otherwise, we may recover the amount in the form of salary, wages, or benefits payable under any company-sponsored benefit plans, including this Plan. We also reserve the right to recover any overpayment by legal action or offset payments on future Eligible Expenses.

If the Plan overpays a health care provider, the Claims Administrator reserves the right to recover the excess amount, by legal action if necessary.

Refund of Overpayments

If we pay Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to us if any of the following apply:

- All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment we made exceeded the Benefits under the Plan.
- All or some of the payment was made in error.

The refund equals the amount we paid in excess of the amount that should have paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help us get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future Benefits that are payable under the Plan. The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future Benefits.

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Limitation of Action

You cannot bring any legal action against us or the Claims Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in (Section 5: How to File a Claim) and all required reviews of your claim have been completed. If you want to bring a legal action against us or the Claims Administrator you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against us or the Claims Administrator.

You cannot bring any legal action against us or the Claims Administrator for any other reason unless you first complete all the steps in the appeal process described in this document. After completing that process, if you want to bring a legal action against us or the Claims Administrator you must do so within three years of the date you are notified of our final decision on your appeal or you lose any rights to bring such an action against us or the Claims Administrator.

Qualified Medical Child Support Orders (QMCSOs)

A qualified medical child support order (QMCSO) is a judgment, decree or order issued by a court or appropriate state agency that requires a child to be covered for medical benefits. Generally, a QMCSO is issued as part of a paternity, divorce, or other child support settlement.

If the Plan receives a medical child support order for your child that instructs the Plan to cover the child, the Plan Administrator will review it to determine if it meets the requirements for a QMCSO. If it determines that it does, your child will be enrolled in the Plan as

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your Dependent, and the Plan will be required to pay Benefits as directed by the order.

You may obtain, without charge, a copy of the procedures governing QMCSOs from the Plan Administrator.

Note: A National Medical Support Notice will be recognized as a QMCSO if it meets the requirements of a QMCSO.

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Section 10: Glossary of Defined Terms

This section:

- Defines the terms used throughout this SPD.
- Is not intended to describe Benefits.

Addendum - any attached written description of additional or revised provisions to the Plan. The benefits and exclusions of this SPD and any amendments thereto shall apply to the Addendum except that in the case of any conflict between the Addendum and SPD and/or amendments to the SPD, the Addendum shall be controlling.

Alternate Facility - a health care facility that is not a Hospital, or a facility that is attached to a Hospital and that is designated by the Hospital as an Alternate Facility. This facility provides one or more of the following services on an outpatient basis, as permitted by law:

- Pre-scheduled surgical services.
- Emergency Health Services.
- Pre-scheduled rehabilitative, laboratory or diagnostic services.

An Alternate Facility may also provide Mental Health Services or Substance Use Disorder Services on an outpatient or inpatient basis.

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Amendment - any attached written description of additional or revised provisions or Benefits to the Plan. Amendments are subject to all conditions, limitations and exclusions of the Plan, except for those that are specifically amended.

Annual Deductible - the amount you must pay for Covered Health Services in a calendar year before we will begin paying for Benefits in that calendar year.

The actual amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses below.

Any amount you pay for medical expenses in the last three months of the previous calendar year, that is applied to the previous Annual Deductible, will be carried over and applied to the current Annual Deductible. This carry-over feature applies only to the individual Annual Deductible.

Benefits - your right to payment for Covered Health Services that are available under the Plan. Your right to Benefits is subject to the terms, conditions, limitations and exclusions of the Plan, including this SPD and any applicable Riders and Amendments.

BMI - a measure used in obesity risk assessment to determine the degree of obesity by approximating the measure of total body fat as compared with the assessment of body weight alone. Also referred to as Body Mass Index.

Certificate of Creditable Coverage - A document furnished by a group health plan or a health insurance company that shows the amount of time the individual has had coverage. This document is used to reduce or eliminate the length of time a preexisting condition exclusion applies.

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Claims Administrator - the company (including its affiliates) that provides certain claim administration services for the Plan.

Clinical Trial - a scientific study designed to identify new health services that improve health outcomes. In a Clinical Trial, two or more treatments are compared to each other and the patient is not allowed to choose which treatment will be received.

Coinsurance – see Copayment

Congenital Anomaly - a physical developmental defect that is present at birth, and is identified within the first twelve months of birth.

Congenital Heart Disease Program Services - the Claims Administrator's program made available by the Employer to Employees. The Congenital Heart Disease Resource Services program provides information to Employees or their Covered Dependents with congenital heart disease and offers access to additional centers for the treatment of congenital heart disease.

Copayment/Coinsurance - the charge you are required to pay for certain Covered Health Services. A Copayment may be either a set dollar amount or a percentage of Eligible Expenses. Coinsurance is the charge you are required to pay as a percent of eligible expenses.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by Personal Health Support on our behalf.

Covered Health Service(s) -those health services provided for the purpose of preventing, diagnosing or treating a Sickness, Injury, Mental Illness, Substance Use Disorder, or their symptoms.

A Covered Health Service is a health care service or supply described in Section 1: What's Covered--Benefits as a Covered Health Service, which is not excluded under Section 2: What's Not Covered--Exclusions, including Experimental or Investigational Services and Unproven Services.

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Covered Health Services must be provided:

- When the Plan is in effect;
- Prior to the effective date of any of the individual termination conditions set forth in this Summary Plan Description; and
- Only when the person who receives services is a Covered Person and meets all eligibility requirements specified in the Plan.

Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies, as described.

Covered Person - either the Employee or an Enrolled Dependent, but this term applies only while the person is enrolled under the Plan. References to "you" and "your" throughout this SPD are references to a Covered Person.

Custodial Care - services that:

- Are non-health related services, such as assistance in activities of daily living (including but not limited to feeding, dressing, bathing, transferring and ambulating); or
- Do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Dependent - the Employee's legal spouse, as recognized by Washington state law, unless he or she is enrolled in one of the Plans as an Employee or Retiree, or a Dependent child up to the age of 26 of the Employee or the Employee's spouse. All references to the spouse of an Employee shall include a registered Domestic Partner, as recognized by Washington state law.

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Under the following circumstances, HEWT-sponsored health coverage can be continued upon reaching limiting age.

Your child is not able to be self-supporting by reason of mental retardation or a physical handicap, provided:

- the handicap existed before limiting age (see above), and
- the child was covered as a dependent prior to reaching limiting age, and
- the child is principally dependent on you for support, and
- proof of the child's condition and dependence is submitted prior to the date coverage would otherwise have ended.

We may require that the child be examined by a physician chosen by us at our cost. You may be required to continue to provide proof that the child meets the conditions of incapacity and dependency. If you do not provide proof of the child's incapacity and dependency within 30 days of request, coverage for the child will end.

The Employee must reimburse us for any Benefits that we pay for a child at a time when the child did not satisfy the conditions for eligibility.

A Dependent also includes a child for whom health care coverage is required through a 'Qualified Medical Child Support Order' or other court or administrative order. We are responsible for determining if an order meets the criteria of a Qualified Medical Child Support Order.

A Dependent does not include anyone who is also enrolled as an Employee. No one can be a Dependent of more than one Employee.

Designated United Resource Network Facility - a Hospital that the Claims Administrator names as a Designated United Resource Network Facility. A Designated United Resource Network Facility

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has entered into an agreement with the Claims Administrator to render Covered Health Services for the treatment of specified diseases or conditions. To be considered a Designated Facility, a facility must meet certain standards of excellence and have a proven track record of treating specified conditions.

Domestic Partner - a person of the opposite or same sex with whom the Employee has established a domestic partnership as recognized/registered by Washington state law.

Durable Medical Equipment - medical equipment that is all of the following:

- Can withstand repeated use.
- Is not disposable.
- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Is appropriate for use in the home.

Eligible Class – the class of Employees designated by the Plan Sponsor as eligible to participate in the Plan. See Attachment II.

Eligible Expenses - the amount we will pay for Covered Health Services, incurred while the Plan is in effect, are determined as stated below:

Eligible Expenses are based on either of the following:

- When Covered Health Services are received from Network providers, Eligible Expenses are the contracted fee(s) with that provider.
- When Covered Health Services are received from PPO Non-Network providers, the Claims Administrator calculates Eligible

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Expenses based on available data resources of competitive fees in that geographic area, unless you received services as a result of an Emergency or as otherwise arranged through the Claims Administrator. In this case, Eligible Expenses are the fee(s) that are negotiated with the non-Network provider.

Eligible Expenses are determined solely in accordance with the Claim Administrator's reimbursement policy guidelines. The reimbursement policy guidelines are developed, in the Claim Administrator's discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that the Claims Administrator accepts.

Eligible Dependent or Eligible Dependent Child – a Dependent who is eligible for coverage under a HEWT-sponsored health plan at the time of the Eligible Person's enrollment under this Plan.

Eligible Person - A regular part-time Employee of the Plan Sponsor who is scheduled to work at his or her job at least 20 hours per week. To be an Eligible Person, an Employee must be in an Eligible Class.

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Emergency - a serious medical condition or symptom resulting from Injury, Sickness or Mental Illness which is both of the following:

- Arises suddenly.
- In the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.

Emergency Health Services - health care services and supplies necessary for the treatment of an Emergency.

Employee – a regular full-time or part-time employee of the Sponsor Employer, with a minimum of 20 hours per week. An Eligible Person who is properly enrolled under the Plan. The Employee is the person (who is not a Dependent) on whose behalf the Plan is established.

Enrolled Dependent - a Dependent who is properly enrolled under the Plan.

Experimental or Investigational Services - medical, surgical, diagnostic, psychiatric, substance use disorder or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time a determination is made regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are FDA approved under

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the Humanitarian Use Device exemption are not considered to be Experimental or Investigational.)

- The subject of an ongoing Clinical Trial that meets the definition of a Phase I, II or III Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Exceptions:

- Clinical Trials for which Benefits are available as described in (Section 1: What's Covered--Benefits) under the heading *Clinical Trials*.
- If you are not a participant in a qualifying Clinical Trial as described in (Section 1: What's Covered--Benefits) under the heading *Clinical Trials* and have a Sickness or condition that is likely to cause death within one year of the request for treatment we and the Claims Administrator may, at their discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, we and the Claims Administrator must determine that although unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Health Statement(s) - a single, integrated statement that summarized EOB information by providing detailed content on account balances and claim activity.

Home Health Agency - a program or organization authorized by law to provide health care services in the home.

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Hospital - an institution, operated as required by law, that is both of the following:

- Is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- Has 24 hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a nursing home, convalescent home or similar institution.

Initial Enrollment Period - the initial period of time, as determined by the Plan Administrator, during which Eligible Persons may enroll themselves and their eligible Dependents under the Plan.

Injury - bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility - a Hospital (or a special unit of a Hospital that is designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay - an uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Outpatient Treatment - a structured outpatient Mental Health or Substance Use Disorder treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.

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Medicare - Parts A, B, and C of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Services - Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment for the condition is a Covered Health Service.

MH/SUD (Mental Health/Substance Use Disorder) Administrator - the organization or individual, designated by the Claims Administrator, that provides or arranges Mental Health Services and Substance Use Disorder Services for which Benefits are available under the Plan.

Mental Illness - those mental health or psychiatric diagnostic categories that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless those services are specifically excluded under the Plan.

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect with the Claims Administrator or an affiliate (directly or through one or more other organizations) to provide Covered Health Services to Covered Persons.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some of our products. In this case, the provider will be a Network provider for the Health Services and products included in the participation agreement, and a PPO Non-Network provider for other Health Services and products. The participation status of providers will change from time to time.

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Open Enrollment Period - a period of time that follows the Initial Enrollment Period during which Eligible Persons may enroll themselves and eligible Dependents under the Plan. The Plan Administrator will determine the period of time that is the Open Enrollment Period.

Out-of-Pocket Maximum – as shown under Payment Section on page 7, shows the maximum amount of Coinsurance you pay every calendar year. If you use both PPO Network Benefits and PPO Non-Network Benefits, two separate Out-of-Pocket Maximums apply. Depending on the geographic area and the service you receive, you may have access to Non-Network providers who have agreed to discount their charges for Covered Health Services. If you receive Covered Health Services from these providers, your Coinsurance for Non-Network Benefits will remain the same, however the total amount that you owe may be less than if you received services from other Non-Network providers because the Eligible Expenses may be a lesser amount.

Once you reach the Out-of-Pocket Maximum, Benefits for those Covered Health Services that apply to the Out-of-Pocket Maximum are payable at 100% of Eligible Expenses during the rest of that calendar year.

The following costs will never apply to the Out-of-Pocket Maximum:

- Any charges for non-Covered Health Services.
- Copayments for or Coinsurance Covered Health Services available by an optional Rider.
- The amount of any reduced Benefits if you don't notify Personal Health Support as described in Section 1: What's Covered--Benefits under the *Must You Notify Personal Health Support*? column.

To continue reading, go to left column on next page.

- Charges that exceed Eligible Expenses.

Even when the Out-of-Pocket Maximum has been reached, the following will not be paid at 100%:

- Any charges for non-Covered Health Services.
- The amount of any reduced Benefits if you don't notify Personal Health Support as described in Section 1: What's Covered--Benefits under the *Must You Notify Personal Health Support*? column.
- Charges that exceed Eligible Expenses.

Partial Hospitalization/Day Treatment – a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.

Personal Health Support - programs provided by UnitedHealthcare that focus on prevention, education, and closing the gaps in care designed to encourage an efficient system of care for you and your covered Dependents.

Physician - any Doctor of Medicine, "M.D.", or Doctor of Osteopathy, "D.O.", who is properly licensed and qualified by law.

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that we describe a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Plan.

Plan - HEWT PPO and Out-of-Area Plan for Hanford Employee Welfare Trust Health Benefit Plan.

To continue reading, go to right column on this page.

Plan Administrator - is the Hanford Employee Welfare Trust or its designee as that term is defined under ERISA. References to "we," "us," and "our" in this SPD refer to the Plan Administrator.

PPO Network Benefits - Benefits for Covered Health Services that are provided by a Network Physician or other Network provider.

PPO Non-Network Benefits - Benefits for Covered Health Services that are provided by a non-Network Physician or other non-Network provider.

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with Pregnancy.

Private Duty Nursing - nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or home setting when any of the following are true:

- no skilled services are identified;
- skilled nursing resources are available in the facility;
- the skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose; or
- the service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or home-care basis, whether the service is skilled or non-skilled independent nursing.

Residential Treatment Facility – a facility which provides a program of effective Mental Health Services or Substance Use

To continue reading, go to left column on next page.

Disorder Services treatment and which meets all of the following requirements:

- It is established and operated in accordance with applicable state law for residential treatment programs.
- It provides a program of treatment under the active participation and direction of a Physician and approved by the MH/SUD Administrator.
- It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services in a 24-hour per day, structured milieu.
  - —room and board;
  - —evaluation and diagnosis;
  - —counseling; and
  - —referral and orientation to specialized community resources.

A Residential Treatment Facility that qualifies as a Hospital is considered a Hospital.

Rider - any attached written description of additional Covered Health Services not described in this SPD. Riders are subject to all conditions, limitations and exclusions of the Plan except for those that are specifically amended in the Rider.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

To continue reading, go to right column on this page.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this SPD does not include Mental Illness or Substance Use Disorder.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law.

Spinal Treatment - detection or correction (by manual or mechanical means) of subluxation(s) in the body to remove nerve interference or its effects. The interference must be the result of, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Sponsoring Employer or Plan Sponsor – means the Employers sponsoring the Plan. See Attachment II.

Substance Use Disorder Services - Covered Health Services for the diagnosis and treatment of alcoholism and Substance Use Disorder disorders that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless those services are specifically excluded. The fact that a disorder is listed in the Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment of the disorder is a Covered Health Service.

Transitional Care – Mental Health Services/Substance Use Disorder Services that are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- sober living arrangements such as drug-free housing, alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to

To continue reading, go to left column on next page.

ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

- supervised living arrangement which are residences such as transitional living facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

UnitedHealth MyNurse℠ - the primary nurse that may be assigned to you if you have a chronic or complex health condition. This nurse will call you to assess your progress, and provide you with information and education.

UnitedHealth Premium Program - a program that identifies Network Physicians or facilities that have been designated as a UnitedHealth Premium program Physician or facility for certain medical conditions.

Physicians and facilities must meet program criteria in order to be designated as a UnitedHealth Premium provider. The fact that a Physician or facility is a Network Physician or facility does not mean that it is a UnitedHealth Premium program Physician or facility.

Unproven Services - services that are not consistent with conclusions of prevailing medical research which demonstrate that the health service has a beneficial effect on health outcomes and that are not based on trials that meet either of the following designs.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies, as described.

If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we and the Claims Administrator may, in our discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we and the Claims Administrator must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Urgent Care Center - a facility, other than a Hospital, that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

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Vision Care Rider

Hanford Employee Welfare Trust (HEWT)

UnitedHealthcare Vision PPO Plan

Effective: January 1, 2014

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Vision Care Plan Rider

This Rider to the Summary Plan Description provides Benefits for vision care.

Benefits are provided for vision care at either a UnitedHealthcare Vision and Optum Care Network Provider, a UnitedHealthcare Vision and Optum Care-approved laboratory.

When we use the words "we," "us," and "our" in this document, we are referring to the Plan Administrator. When we use the words "you" and "your" we are referring to people who are Covered Persons as the term is defined in the Summary Plan Description Section 10: Glossary of Defined Terms.

NOTE: The Coordination of Benefits provision Section 7: Coordination of Benefits in the Summary Plan Description does not apply to vision care covered through this Rider. Vision care Benefits will not be coordinated with those of any other health coverage plan.

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Introduction

Summary of Coverage

UnitedHealthcare Vision (*formerly Spectera*) has an extensive nationwide network of doctors who provide quality eye care and materials. This Plan is designed to provide for regular eye examinations and benefits toward vision care expenses including glasses or contact lenses.

How the Plan Works

When you are ready to obtain vision care services, call your UnitedHealthcare Vision participating doctor. If you need to locate a UnitedHealthcare Vision participating doctor, call UnitedHealthcare Vision 800-638-3120 or visit our Web site at www.myuhcvision.com.

When making an appointment, identify yourself as a UnitedHealthcare Vision member. The participating doctor will also need the covered member's Social Security number, and the covered member's group name. The participating doctor will contact UnitedHealthcare Vision to verify your eligibility and plan coverage. The participating doctor will also obtain authorization for services and materials. If you are not eligible, the UnitedHealthcare Vision doctor will notify you.

At your appointment, the participating doctor will provide an eye examination and determine if eyewear is necessary. If so, the participating doctor will coordinate the prescription with a UnitedHealthcare Vision-approved, contract laboratory. The participating doctor will itemize any non-covered charges and have you sign a form to document that you received services.

To continue reading, go to right column on this page.

UnitedHealthcare Vision will pay the participating doctor directly for covered services and materials.

You are responsible for paying the doctor any applicable copayment(s), and any additional costs resulting from cosmetic options, or non-covered services and materials you have selected. Selecting a participating doctor from UnitedHealthcare Vision's network assures direct payment to the doctor and guarantees quality services and materials.

Network Benefits

When using a Network Provider, enrolled participants and eligible Dependents are eligible for the following.

Examination: 100% covered once every 12 months. A comprehensive vision examination is provided by a network optometrist or ophthalmologist after a $10 copay.

Eyewear: After the material copay, lenses are 100% covered every 12 months. After the material copay, frames within the UnitedHealthcare Vision selection or allowance are 100% covered every 24 months. The material copay is $10. This applies to the entire purchase, not the lens and frame individually.

To continue reading, go to left column on next page.

Services From a Non-Participating Doctor

The majority of UnitedHealthcare Vision's patients receive services from participating doctors, although you may select any licensed vision care provider for services. Your reimbursement schedule does not guarantee full payment, nor can UnitedHealthcare Vision guarantee patient satisfaction, when services are obtained from a non-participating provider.

If you elect vision coverage and choose to use a non-Network Provider, you will be reimbursed at **85% of the Reasonable and Customary amount up to $165.00 per participant per year:.**

Eye examination:	**Once each 12 months***
Spectacle Lenses:	**Once each 24 months***
Frame:	**Once each 24 months***

***from your last date of service**

To continue reading, go to right column on this page.

Follow these steps if you obtain services and/or materials from a non-participating provider:

- Pay the provider the full amount of the bill and request a copy of the bill that shows the amount of the eye examination, lens type, and frame.
- Send a copy of the itemized bill(s) to UnitedHealthcare Vision. The following information **must** also be included in your documentation.
- Member's name and mailing address;
- Member's Social Security number;
- Member's employer or group name; and
- Patient's name, relationship to member, and date of birth.

You may submit the information on a HCFA-1500 form or any generic insurance claim form that may be available from your non-participating provider upon request.

To continue reading, go to left column on next page.

Section 1: What's Covered -- Vision Care Benefits

Standard Eye Examination and Glasses

Eye examination:	Once each 12 months*
Spectacle Lenses:	Once each 12 months*
Frame:	Once each 24 months*

**from your last date of service*

Spectacle Lenses and Frames

UnitedHealthcare Vision covers a wide selection of frames, but not all frames will be covered in full. When a patient selects a frame that exceeds the plan's allowance, these additional charges are administered at controlled costs. UnitedHealthcare Vision also has controlled costs for cosmetic options, and these charges are typically less than usual and customary fees. Please consult your participating provider about lens options which may be cosmetic in nature, and may result in additional charges.

Elective or Medically Necessary contact lenses may be provided instead of glasses.

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Lenses

If prescribed, a pair of single vision or standard multi-focal lenses.

Frames

Your choice from a wide selection of fashionable frames will be covered. If you select a frame from outside the UnitedHealthcare Vision Selection, you will be given a $50 wholesale frame allowance. At retail optical providers, you will be able to choose from a wide variety of Selection frames, or receive a discount off of already reduced prices.

Contact Lenses

In lieu of lenses and a frame, you may select contact lenses. UnitedHealthcare Vision offers a wide variety of Selection contact lenses from many leading manufacturers (over 85% of participants choose from the UnitedHealthcare Vision Selection). Four boxes (12 pairs) of covered disposables are included when obtained from a network provider. A $105 credit will be applied toward the evaluation, fitting, and purchase of Non-Selection contact lenses once every 12 months. Please note: To receive the full $105 credit, you must receive your exam, fitting and evaluation at the same provider.

Patient Options

Standard scratch coating is offered at no additional cost to the participant. Should you choose patient options not covered by the program such as tints, progressive lenses, UV, and anti-reflective coating, you will be able to purchase these options at a significant discount. This

To continue reading, go to left column on next page.

additional benefit may save you 20% to 40% off of retail on cosmetic lens options and lens upgrades.

Laser Eye Surgery

UnitedHealthcare Vision participants receive access to discounted refractive eye surgery procedures from numerous provider locations throughout the United States. To find a participating Laser Eye Surgeon in your area, visit our web site at www.myuhcvision.com.

To continue reading, go to right column on this page.

Medically Necessary Contact Lenses:

Covered in full when prescribed by a participating doctor for one of the following conditions:

- Following cataract surgery.

Not Covered

- To correct extreme vision problems that cannot be corrected with spectacle lenses;
- With certain conditions of anisometropia; or
- With certain conditions of keratoconus.

The participating doctor must secure prior approval from UnitedHealthcare Vision for Medically Necessary contact lenses.

To continue reading, go to left column on next page.

Section 2: What's Not Covered -- Exclusions

This plan is designed to cover your visual needs rather than cosmetic materials. If you select any of the following, you will be responsible for an additional charge:

- Blended lenses;
- Oversize lenses;
- Progressive multifocal lenses;
- Photochromic or tinted lenses other than Pink 1 or 2;
- Coated or laminated lenses;
- A frame that exceeds the plan allowance;
- Certain limitations on low vision care;
- Cosmetic lenses;
- Optional cosmetic processes; or
- UV protected lenses.

To continue reading, go to right column on this page.

The following professional services or materials are not covered. Discounts may apply to some items.

- Orthoptics or vision training and any associated supplemental testing;
- Plano lenses (non-prescription)
- Two pair of glasses in lieu of bifocals;
- Lenses and frames furnished under this program which are lost or broken will not be replaced except at the normal intervals when services are otherwise available;
- Medical or surgical treatment of the eyes;
- Any eye examination, or any corrective eyewear, required by an employer as a condition of employment; or
- Corrective vision services, treatments, and materials of an experimental nature.

This is only a summary. For additional information, see your employer's benefits representative.

To continue reading, go to left column on next page.

Section 3: Claims Administration

Filing Claims

Please mail the itemized bill(s) and claim form to the following address:

UnitedHealthcare Vision

Attention: Claims Department

PO BOX 30978

Salt Lake City, UT 84130

Please note that claims for reimbursement must be filed within one year of the date services were completed.

If you need further information about your plan's reimbursement schedule, contact your employer.

To continue reading, go to right column on this page.

Claim Review Procedure

If a claim for benefits is denied, a written request may be submitted to UnitedHealthcare Vision for a full review of the denial. This request must be made within 60 days of the denial. The exercise this option, call UnitedHealthcare Vision at **1-800-638-3120** to obtain details on procedures to follow.

- **End of Vision Care Plan Rider** -

To continue reading, go to left column on next page.

Attachment I

Women's Health and Cancer Rights Act of 1998

As required by the Women's Health and Cancer Rights Act of 1998, we provide Benefits under the Plan for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Services (including Copayments and any Annual Deductible) are the same as are required for any other Covered Health Service. Limitations on Benefits are the same as for any other Covered Health Service.

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Statement of Rights under the Newborns' and Mothers' Health Protection Act

Group health Plans and, health insurance issuers generally may not, under Federal law, restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

In any case, Plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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Attachment II

Summary Plan Description

Name of Plan: Hanford Employee Welfare Trust (PPO)

Name of Employers sponsoring the Plan: A complete list of Employers sponsoring the Plan may be obtained by Participants and Beneficiaries upon written request to the Plan Administrator and is available for examination by Participants and Beneficiaries as required by Department of Labor Regulation Sections 2520.104b-1 and 2520.104b-30.

For a listing of the Employer Sponsors see the Wrapper document Schedule B posted on the HEWT home page.

Incumbent Employees are identified in the applicable prime contract with the Department of Energy or applicable subcontract agreement.

Name, Address and Telephone Number of Plan Administrator and Named Fiduciary:

Hanford Employee Welfare Trust
c/o Mission Support Alliance, LLC
P. O. Box 650, MSIN H2-23
Richland, WA 99352
(509) 372-8284

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The Plan Administrator retains all fiduciary responsibilities with respect to the Plan except to the extent the Plan Administrator has delegated or allocated to other persons or entities one or more fiduciary responsibility with respect to the Plan.

Employer Identification Number (EIN): 91-2017261

IRS Plan Number: 550

Effective Date of Plan: January 1, 2003; restatement January 1, 2010; restatement January 1, 2011; restatement January 1, 2012; restatement March 1, 2012; restatement January 1, 2014.

Type of Plan: Group health care coverage plan

Name, Business, Address, and Business Telephone Number of Trustees:

Trustees of the Hanford Employee Welfare Trust
c/o Mission Support Alliance, LLC
P. O. Box 650, MSIN H2-23
Richland, WA 99352
(509) 372-8284

Claims Administrator: The company which provides certain administrative services for the Plan.

United HealthCare Services, Inc.
185 Asylum Street, Hartford, CT 06103-3408

The Claims Administrator shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of Benefits under the Plan. The Claims Administrator shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan.

To continue reading, go to left column on next page.

Type of Administration of the Plan: The Plan Administrator provides certain administrative services in connection with its Plan. The Plan Administrator may, from time to time in its sole discretion, contract with outside parties to arrange for the provision of other administrative services including arrangement of access to a Network Provider; claims processing services, including coordination of Benefits and subrogation; utilization management and complaint resolution assistance. This external administrator is referred to as the Claims Administrator. The Plan Administrator also has selected a provider network established by United HealthCare Services, Inc. The named fiduciary of Plan is Hanford Employee Welfare Trust, the Plan Administrator.

Person designated as agent for service of legal process: The name and address of the Agent for Service of Legal Process for the Plan is:

Jason T. Froggatt
Davis Wright Tremaine LLP
1201 Third Avenue
Suite 2200
Seattle, Washington 98101 – 3045

Legal process may also be served upon a Plan Trustee or the Plan Administrator.

Source of contributions under the Plan: The sources of the contributions to the Plan are Employer and Employee contributions.

Method of calculating amount of contribution: Employee required contributions are determined by each Plan Sponsor. A schedule of such required contributions will be made available to eligible persons.

The Hanford Employee Welfare Trust is a funding medium through which benefits are provided.

To continue reading, go to right column on this page.

Date of the end of the year for purposes of maintaining Plan's fiscal records: Plan year shall be a twelve month period ending December 31.

Determinations of Qualified Medical Child Support Orders: The Plan's procedures for handling qualified medical child support orders are available without charge upon request to the Plan Administrator.

Reservation of Rights to Amend or Terminate: Although each Plan Sponsor currently intends to continue the Benefits provided by this Plan, each Plan Sponsor reserves the right, at any time and for any reason or no reason at all, to change, amend, interpret, modify, withdraw or add Benefits or terminate this Plan or this Summary Plan Description, in whole or in part and in its sole discretion, without prior notice to or approval by Plan participants and their beneficiaries. Any change or Amendment to or termination of the Plan, its Benefits or its terms and condition, in whole or in part, shall be made solely in a written Amendment (in the case of a change or Amendment) or in a written resolution (in the case of termination), whether prospective or retroactive, to the Plan. The Amendment or resolution is effective only when approved by the body or person to whom such authority is formally granted by the terms of the Plan. No person or entity has any authority to make any oral changes or Amendments to the Plan.

Additional Information: Benefits under the Plan are furnished in accordance with the Plan Description issued by the Plan Administrator, including this Summary Plan Description.

Participant's rights under the Employee Retirement Income Security Act of 1974 (ERISA) and the procedures to be followed in regard to denied claims or other complaints relating to the Plan are set forth in the body of this Summary Plan Description.

To continue reading, go to left column on next page.

Statement of Employee Retirement Income Security Act of 1974 (ERISA) Rights

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of the summary annual report.

To continue reading, go to right column on this page.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or eligible Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your eligible Dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health Plan, if you have creditable coverage from another group health Plan. You should be provided a Certificate of Creditable Coverage in writing, free of charge, from your group health Plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. You may request a Certificate of Creditable Coverage by contacting the Plan Administrator. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

To continue reading, go to left column on next page.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for Benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court after all required reviews of your claim have been completed. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, United States Department of Labor listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publication hotline of the Employee Benefits Security Administration.

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The benefits administered by UnitedHealthcare are described above.

Please contact UnitedHealthcare with any questions on these health benefits.

The ***Pharmacy Benefit Program*** described in the pages that follow below are relate to coverage administered by Express Scripts, Inc.

Please contact Express Scripts with respect to these pharmacy benefits.

Prescription Drug Benefits

Hanford Employee Welfare Trust (HEWT)

Express Scripts, Inc. Providing Pharmacy benefits for those enrolled in the "PPO" Medical Plan

for

Employee and Eligible Dependents

Effective Date: January 1, 2014

Prescription Drug Benefits

A separate Pharmacy Benefit Program covers prescription drugs. UnitedHealthcare does not administer the prescription drug portion of this Employee medical plan. This program is administered by Express Scripts. There are two ways you can purchase prescription drugs, from a participating **retail** pharmacy or by using **mail order**. This Prescription Program in effect as of March 1, 2012, and administered by Express Scripts, is briefly described below. More details of the program are available directly from Express Scripts.

Express Scripts, Inc. "Step Therapy" Prescription Program:

A program called "Step Therapy" applies to employees receiving pharmacy benefits through Express Scripts, Inc. The program is intended to make prescription drugs more affordable for most members and will help HEWT control the rising cost of prescription drugs. Step Therapy is a prescription management program for participants with new conditions that require maintenance medication. In Step Therapy, the covered drugs you take are organized in a series of "steps," with your doctor approving and writing your prescriptions.

- The program usually starts with generic or preferred brand drugs as the "first step." Rigorously tested and approved by the U.S. Food & Drug Administration (FDA), the generics covered by the program have been proven to be effective in treating many medical conditions. This first step allows you to begin or continue treatment with safe, effective prescription drugs that are also affordable. Your co-payment is usually the lowest with a first-step drug.
- More expensive brand-name or non-preferred brand drugs are usually covered in the "second step."

To continue reading, go to right column on this page.

- Your doctor is consulted, approving and writing your prescriptions based on the list of Step Therapy drugs covered by the program. For instance, your doctor must write your new prescription when you change from a second-step drug to a first-step one.

Please refer to the materials which were recently distributed for additional information on the "Step Therapy" Prescription Program or, if you have questions, contact Express Scripts Mail Service Pharmacy directly at **1-800-796-7518**.

Express Scripts, Inc.'s CuraScript for Patients With Specialty Medication Needs

Through CuraScript, Express Scripts, Inc. patients have access to many services not available through retail pharmacies. Patient care Coordinators, nurses and pharmacists specifically trained in specialty pharmacy interact directly with patients to educate them about their disease, treatment platform and side effects. They also coordinate physician visits, lab results, and drug fulfillment to ensure correct dosing and timing of treatment administration. Additionally, on-staff social workers provide patients with emotional support and help identify community assistance programs in their area.

What are Specialty Medications?

Specialty medications treat patients with chronic and complex conditions such as MS, inflammatory conditions, cancer, blood cell deficiency, bone conditions, growth deficiency, pulmonary hypertension, anticoagulant, infertility, rheumatoid arthritis, and Hepatitis C. These drugs can require frequent dosing adjustments, intensive clinical monitoring, patient training and specialized handling. They may also require specialized administration, such as

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injections. Specialty medications can cost more than $500 for a 30-day supply, with the average specialty prescription costing $1,300 per month.

CuraScript prospectively monitors dates when patients should need new refills and proactively calls each patient 10 to 14 days prior to the next refill date to schedule delivery. If a patient calls Express Scripts, the refill process is seamless to the patient. An Express Scripts representative personally transfers the patient to a CuraScript care coordinator to process the refill request.

Why Did We Choose CuraScript Specialty Pharmacy?

CuraScript's close-touch business model is patient-focused, concentrating on delivering a higher level of personal care, service and value to meet the complex needs of specialty patients.

Your Share of the Cost (Co-payments)

Both the mail and the retail programs have "three-tier" co-payment structures for active employees enrolled in the PPO Plan. When you purchase a prescription, your cost will be the required co-payment (or you can pay the actual cost of the drug, if it is less than the applicable co-payment amount.) The co-payment depends on whether it is from retail or mail order.

The three categories, or tiers, are:

Generic: Drugs for which the patent has expired, allowing other manufacturers to produce and distribute the product under a generic name. Generics are essentially a chemical copy of their brand-name equivalents. The color or shape may be different, but the active ingredients must be the same for both.

Preferred Brand Name: A drug with a trade name under which the product is advertised and sold, and is protected by patents so that it can only be produced by one manufacturer for 7 years.

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Non-Preferred Brand Name: A brand name medication that has been reviewed by a Pharmacy and Therapeutics committee (physicians and pharmacists) who determine that an alternative drug that is clinically equivalent and more cost effective is available.

Your druggist can determine the category of a drug, or you can contact Express Scripts by calling their toll-free Customer Service line at **1-800-796-7518**. You can also contact them via the internet at www.express-scripts.com.

The Express Scripts – Administered Prescription Program Includes The Following Features:

- There is an annual maximum out-of-pocket limit of $1,500 per member. Both mail and retail co-payment amounts apply in the calculation.
- NO DEDUCTIBLE.
- Co-payment amounts for both mail and retail prescription are subject to change based on costs and other factors.
- There are no replacement prescriptions allowable under the plan.
- Quantity limits may apply to some drugs. These are determined by the manufacturer and are subject to change.

Most prescription drugs are available to you under the Plan. They will be dispensed as written by the physician. However, you will pay more out-of-pocket if you request a brand-name drug when the prescription is written for a generic drug.

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What's Not Covered—Pharmacy Exclusions:

Drugs that are NOT covered by the plan include, but are not limited to, the following:

- multiple vitamins (including vitamins with fluoride)
- prenatal vitamins
- appetite suppressants
- injectable drugs, except for ESI selected injectables. (Contact Express Scripts for specific information)
- medications for cosmetic purposes (e.g. Rogaine)
- medications with no FDA indications (e.g. yohimbine)
- nystatin oral powder
- progesterone products (including compounded forms)
- over-the-counter (OTC) medications or products equivalent to OTC medications
- vitamin B12
- smoking deterrents
- anorexiants or other drugs used for weight control
- DESI drugs (drugs determined by the Food and Drug Administration to lack substantial evidence of effectiveness)
- drugs labeled "Caution - limited by federal law to investigational use" or experimental drugs
- therapeutic devices or appliances, support garments and other non-medical substances
- immunizing agents, biologicals, blood and blood plasma
- Accutane (Isotretinoin)

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Prescription Drug Review

Some prescription drugs require a "prescription drug review" or prior authorization before they may be covered by the Plan. If your pharmacist tells you that your prescription drug requires prior authorization, ask your pharmacist or your doctor to call Express Scripts.

Customer Service Center

The Express Scripts Customer Service Call Center is available 24 hours a day, 365 days a year to help you locate a participating pharmacy or help you better understand and use your program.

To reach the call center, or a pharmacist call toll-free: **1-800-796-7518.** (TDD for hearing impaired: **1-800-899-2114**, or **1-612-797-4566**).

Claims and Appeal Procedure

If you are not satisfied with the disposition of your claim for benefits under the Pharmacy Benefit Program, contact Express Scripts at 1-800-796-7518 to confirm claim denial. If you are not satisfied with the disposition of your claim for benefits, you have the right to appeal to Express Scripts. Your appeal should be filed with Express Scripts within 60 days of the denial of your claim by Express Scripts.

You or your enrolled Dependent may send a written request for an appeal to:

Express Scripts, Inc.
P.O. Box 66583
St. Louis, MO 63166-6583

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Express Scripts will conduct a full and fair review of your appeal. The appeal may be reviewed by:

- An appropriate individual(s) who did not make the initial benefit determination.
- A health care professional with appropriate expertise who was not consulted during the initial benefit determination process.

Prior to issuing a determination on your appeal:

- You have the right to review your claim file and have access to and request copies of documents, records and other information that is relevant to your claim.
- You have the right to present evidence and testimony, including written comments, records and other information, relating to your claim.
- If any new or additional evidence is considered, relied upon or generated by Express Scripts in connection with your claim during the appeal, Express Scripts will provide you with such information, free of charge, prior to the issuance of its determination, and you will have reasonable opportunity to respond.
- If Express Scripts will uphold the denial based on a new or additional rationale, Express Scripts will provide you with such rationale, free of charge, prior to the issuance of its determination, and you will have reasonable opportunity to respond.

Once the review is complete, if Express Scripts upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

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Note: Upon written request and free of charge, any Covered Persons may examine documents relevant to their claim and/or appeals and submit opinions and comments. Express Scripts will review all claims in accordance with the rules established by the U.S. Department of Labor. The decision by Express Scripts will be final, unless you choose to make a voluntary appeal to the Plan Administrator or to request an external review.

Voluntary Appeal

If you are not satisfied with the final determination by Express Scripts, you may choose to make a voluntary appeal to the Plan Administrator. You are not required to make a voluntary appeal before participating in the External Review Program.

Federal External Review Program

If, after exhausting your internal appeals to Express Scripts, you are not satisfied with the final determination, you may choose to participate in the External Review Program. This program only applies if the adverse benefit determination is based on:

- Clinical reasons.
- Rescission of coverage (coverage that was cancelled or discontinued retroactively).
- As otherwise required by applicable law.

This External Review Program offers an independent review process to review the denial of payment. The process is available at no charge to you after exhausting the appeals process identified above and you receive a decision that is unfavorable, or if the Plan Administrator fails to respond to your appeal within the stated time lines.

You may request an independent review of the adverse benefit determination. Neither you nor the Plan Administrator will have an

To continue reading, go to left column on next page.

opportunity to meet with the reviewer or otherwise participate in the reviewer's decision.

All requests for an independent review must be made within four (4) months of the date you receive the adverse benefit determination. You or an authorized designated representative may request an independent review by contacting the toll-free number on your ID card or by sending a written request to the address on your ID card.

The independent review will be performed by an independent Physician, or by a Physician who is qualified to decide whether the requested service or procedure is a Covered Health Service under the Plan. The Independent Review Organization (IRO) has been contracted by Express Scripts and has no material affiliation or interest with Express Scripts or Us. Express Scripts will choose the IRO based on a rotating list of appropriately accredited IROs.

In certain cases, the independent review may be performed by a panel of Physicians, as deemed appropriate by the IRO.

Within applicable timeframes of receipt by Express Scripts of a request for independent review, the request will be forwarded to the IRO, together with:

- All relevant medical records.
- All other documents relied upon by the Plan Administrator in making a decision on the case.
- All other information or evidence that you or your Physician has already submitted to the Plan Administrator.

If there is any information or evidence you or your Physician wish to submit in support of the request that was not previously provided, you may include this information with the request for an independent review, and Express Scripts will include it with the documents forwarded to the IRO. A decision will be made within applicable

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timeframes. If the reviewer needs additional information to make a decision, this time period may be extended. The independent review process will be expedited if you meet the criteria for an expedited external review as defined by applicable law.

The reviewer's decision will be in writing and will include the clinical basis for the determination. The IRO will provide you and the Plan Administrator with the reviewer's decision, a description of the qualifications of the reviewer and any other information deemed appropriate by the organization and/or as required by applicable law.

If the final independent decision is to approve payment or referral, the Plan will accept the decision and provide Benefits for such service or procedure in accordance with the terms and conditions of the Plan. If the final independent review decision is that payment or referral will not be made, the Plan will not be obligated to provide Benefits for the service or procedure.

You may contact Express Scripts at [the toll-free number on your ID card for more information regarding your external appeal rights and the independent review process.

Note: It is your responsibility to notify your employer of any change of address.

Coordination of Benefits (COB)

The coordination of benefits provision described in the Medical Plan above, Section 7, Coordination of Benefits (COB) does not apply to covered Prescription Drugs as described in this section. However, the definitions provided in that section apply here as do the Order of Benefit Determination Rules. This Coordination of Benefits provision applies only when a person has prescription drug coverage under more than one benefit plan.

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Following the Order of Benefit Determination Rules described above in Section 7 determines which Coverage Plan will pay as the Primary Coverage Plan when a person has prescription drug coverage under more than one benefit plan. The Primary Coverage Plan that pays first pays without regard to the possibility that another Coverage Plan may cover some expenses. A Secondary Coverage Plan pays after the Primary Coverage Plan and may reduce the Benefits it pays. However, if this Coverage Plan is the Secondary Coverage Plan, it will not pay any benefits.

Other Coordination of Benefits provisions described in the Medical Plan above in Section 7 are unchanged.

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Retail Prescription Program

Express Scripts offers retail prescription coverage at over 43,000 participating pharmacies nationwide, excluding Walgreens. Check with your pharmacy to see if they are an Express Scripts participant or contact Express Scripts Customer Service for help in locating a participating pharmacy in your area.

Your Cost

The Retail Prescription Program allows you to purchase up to a 34-day supply for a co-payment. Quantity limits may apply based on type of medication prescribed.

The following co-payments apply to prescriptions purchased from a participating retail pharmacy:	
Category*	January 1, 2014 **Co-Payment**
Generic Drugs	$10.00
Preferred Brand-Name	$35.00
Non-Preferred Brand-Name	$50.00

You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Purchasing Prescriptions

At a Participating Retail Pharmacy -

When you purchase a prescription under this plan, you simply present your identification card (provided to you by Express Scripts and co-payment amount. No claim forms are required after co-payment is made.

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At a Retail Pharmacy that is not participating with Express Scripts -

You can also purchase a drug at a non-participating pharmacy. You should pay for the prescription, then submit a claim for reimbursement from Express Scripts.

However, if you purchase from a non-participating pharmacy, your reimbursement will be based on the Express Scripts in-network contracted rate for that drug. You will have to pay the difference between the price charged by the non-Network pharmacy and the Express Scripts contracted rate in addition to the applicable deductible and co-payment amounts.

For non-network retail purchases, complete an Express Scripts claim form and submit your claim and receipts to:

ATTN: Standard Accounts
Express Scripts, Inc.
P.O. Box 66583
St. Louis, MO 63166-6583

Claim forms for out-of-network purchases can be requested from Express Scripts website, www.express-scripts.com, or by calling customer service at **1-800-796-7518**.

Benefits under the Prescription Drug Plan include those for Preventive Care Medications as defined below.

Preventive Care Medications – the medications that are obtained at a Network Pharmacy and that are payable at 100% of the cost (without application of any Copayment, Coinsurance, Annual Deductible, Annual Prescription Drug Deductible or Specialty

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Prescription Drug Annual Deductible) as required by applicable law under any of the following:

- evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
- with respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; or
- with respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

You may determine whether a drug is a Preventive Care Medication through the internet at www.express-scripts.com or by calling the toll-free telephone number on your ID card.

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Mail Order Drug Program

Another option for obtaining prescriptions is the Mail Order Drug Program, which allows you to purchase up to a 90-day supply of most prescription drugs for a single co-payment. The mail order pharmacy program is also administered by Express Scripts.

The Mail Order program works best for drugs that you take on a long-term basis ("maintenance drugs.") Most prescribed drugs and medicines are available to you under the Mail Order Drug Program (generic drugs are dispensed unless your physician directs otherwise). Certain drugs are not available by mail order. Contact Express Scripts Customer Service for more information.

Your Cost

The Mail Order Drug Program allows you to purchase up to a 90-day supply of most prescription drugs for a single co-payment. Quantity limits may apply based on type of medication prescribed.

The following co-payments apply to prescriptions purchased from the Express Scripts Mail Order program:

Category	January 1, 2014 **Co-Payment**
Generic Drugs	$20.00
Preferred Brand-Name	$70.00
Non-Preferred Brand-Name	$100.00

To continue reading, go to right column on this page.

Purchasing Mail-Order Prescriptions

Ask your physician to prescribe needed medication for up to a 90-day supply plus refills. If you, or your eligible dependents, are presently taking medication, ask your doctor for a new prescription. Complete the patient profile questionnaire with your first order. Answer all questions and be sure to include your Social Security number on the form.

You can contact Express Scripts for the necessary mail order form and for other information.

Send the completed mail order form along with your prescription written for up to 90 days and your applicable co-payment. You can submit multiple prescriptions in one envelope; just be sure to include a co-payment for each prescription. Contact Customer Service to determine which category your prescription is: generic, preferred brand name or non-preferred brand-name.

Your prescriptions will be filled and returned to you at the address you have specified on your order form. If you need to change the address please call the 800 (toll-free) number listed on your order form, or you can change the address on the form itself.

Most prescription orders take 14 days to be filled and returned to you unless there are mail delays. If you need a supply of medication while waiting for your mail order prescription, ask your doctor for two prescriptions so you can get a small supply of medication from your local pharmacy while awaiting your Express Scripts prescription.

Once your Express Scripts Mail facility has processed your first prescription, you can order approved refills either by mail or on the internet at www.express-scripts.com.

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Any time you have questions on your medication(s), you can call the Customer Service Department and talk to a pharmacist.

Their toll-free number is: 1-800-796-7518

- **End of Outpatient Prescription Drug Benefits –**